

# Parker Healthcare Management Organization, Inc.

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Certificate # 5301

October 10, 2005

**ATTN: Program Administrator**

**Texas Department of Insurance/Workers Compensation Division**

7551 Metro Center Drive, Suite 100

Austin, TX 78744

Delivered by fax: 512.804.4868

## Notice of Determination

MDR TRACKING NUMBER: M2-05-2315-01  
RE: Independent review for \_\_\_\_

The independent review for the patient named above has been completed.

- Parker Healthcare Management received notification of independent review on 9.8.05.
- Faxed request for provider records made on 9.22.05.
- The case was assigned to a reviewer on 10.5.05.
- The reviewer rendered a determination on 10.10.05.
- The Notice of Determination was sent on 10.10.05.

The findings of the independent review are as follows:

### Questions for Review

Medical necessity of the requested Lumbar Epidural steroid injection at L2-3

### Determination

PHMO, Inc. has performed an independent review of the proposed care to determine if the adverse determination was appropriate. After review of all medical records received from both parties involved, the PHMO, Inc. physician reviewer has determined to **uphold the denial** on the requested service(s).

### Summary of Clinical History

Ms. \_\_\_\_ sustained a work related job injury on \_\_\_\_, while employed with \_\_\_\_\_.

### Clinical Rationale

The patient has had multiple Lumbar surgeries involving the L3-4 and L4-5 levels. The 4.25.2005 Lumbar MRI did not show any L2-3 herniation, only a disc bulge without lateralized findings or significant compromise of the subarachnoid space. The clinical exam is more consistent with a L4-5 radiculopathy. Thus, this request is not validated as a medical necessity as there is no nerve root entrapment at L2-3.

## Clinical Criteria, Utilization Guidelines or other material referenced

Clinical Practice Guideline 14: Acute Low Back Pain in Adults, Bigos, et.al.,1994

This conclusion is supported by the reviewers' clinical experience with over 15 years of patient care and orthopedic surgery.

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The reviewer for this case is a Medical Doctor licensed by the Texas State Board of Medical Examiners. The reviewer is a diplomate of the American Board of Orthopedic Surgery, and is engaged in the full time practice of medicine.

The review was performed in accordance with Texas Insurance Code 21.58C and the rules of Texas Department of Insurance /Division of Workers' Compensation. In accordance with the act and the rules, the review is listed on the DWC's list of approved providers or has a temporary exemption. The review includes the determination and the clinical rationale to support the determination. Specific utilization review criteria or other treatment guidelines used in this review are referenced.

The reviewer signed a certification attesting that no known conflicts-of-interest exist between the reviewer and any of the providers or other parties associated with this case. The reviewer also attests that the review was performed without any bias for or against the patient, carrier, or other parties associated with this case.

### Your Right To Appeal

If you are unhappy with all or part of this decision, you have the right to appeal the decision. The decision of the Independent Review Organization is binding during the appeal process.

If you are disputing the decision (other than a spinal surgery prospective decision), the appeal must be made directly to a district court in Travis County (see Texas Labor Code §413.031). An appeal to District Court must be filed not later than 30 days after the date on which the decision that is the subject of the appeal is final and appealable.

If you are disputing a spinal surgery prospective decision, a request for a hearing must be in writing and it must be received by the Division of Workers' Compensation, Chief Clerk of Proceedings, within ten (10) days of your receipt of this decision. The address for the Chief Clerk of Proceedings would be: P.O. Box 17787, Austin, Texas, 78744.

I hereby verify that a copy of this Findings and Decision was faxed to the Texas Department of Insurance /Division of Workers Compensation, the requestor (if different from the patient) and the respondent. I hereby verify that a copy of this Findings and Decision was mailed to the injured worker (the requestor) applicable to Commission Rule 102.5 this 10<sup>th</sup> day of October, 2005. Per Commission Rule 102.5(d), the date received is deemed to be 5 (five) days from the date mailed and the first working day after the date this Decision was placed in the carrier representative's box.

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Meredith Thomas  
Administrator  
Parker Healthcare Management Organization, Inc.

CC:

Connecticut Indemnity Co/Royal and Sun  
Attn: Delta DelaCruz  
Fax: 972.713.5264

[Claimant]