

Parker Healthcare Management Organization, Inc.

4030 N. Beltline Road, Irving, TX 75038

972.906.0603 972.255.9712 (fax)

Certificate # 5301

December 20, 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: M2-06-0265-01
RE: Independent review for ____

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

- Parker Healthcare Management received notification of independent review on 11.10.05.
- Faxed request for provider records made on 11.14.05.
- TDI-DWC issued an Order for payment on 12.2.05.
- The case was assigned to a reviewer on 12.7.05.
- The reviewer rendered a determination on 12.20.05.
- The Notice of Determination was sent on 12.20.05.

The findings of the independent review are as follows:

Questions for Review

Medical necessity of the proposed right wrist MR-arthrogram.

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 **overturn the denial** on the requested service(s).

Summary of Clinical History

The claimant underwent examination procedures and physical medicine treatments after injuring his left knee, right wrist and low back at work on ____, when he was hit by a scooter traveling at a relatively high rate of speed.

Clinical Rationale

The 10.31.05 letter from carrier's legal counsel stated that the proposed examination should be denied on the basis that the documentation was "too perfunctory to allow any reasonable assessment of the care in question" and referenced a SOAH decision ¹ as its basis. The carrier's law firm has referenced that

¹ SOAH docket no. 453-02-0533.M5

decision in the past – using the same verbatim language – but this reviewer has not been able to confirm that that SOAH decision made that finding.

Nevertheless, in this case, the carrier's allegation is completely without foundation since the provider's treatment notes are extremely detailed, very comprehensive and more than adequately document the medical necessity of the proposed right wrist MRI-arthrogram. Moreover, the proposed diagnostic procedure fulfills statutory requirements² for medical necessity since it offers the patient a very realistic opportunity to obtain relief, achieve promotion of recovery and enhance his ability to return to or retain employment.

Clinical Criteria, Utilization Guidelines or other material referenced

- SOAH docket no. 453-02-0533.M5
- Texas Labor Code 408.021

The reviewer for this case is a doctor of chiropractic peer matched with the provider that rendered the care in dispute. The reviewer is engaged in the practice of chiropractic on a full-time basis.

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 the treating and/or referring provider, the injured employee, the injured employee's employer, the injured employee's insurance carrier, the utilization review agent, or any of the treating doctors or insurance carrier health care providers who reviewed the case for decision before referral to the IRO. 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.

² Texas Labor Code 408.021

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 20th day of December 2005.

Meredith Thomas
Administrator
Parker Healthcare Management Organization, Inc.

CC: Brad Burdin, D.C.
Attn: Jessica
Fax: 210.690.0399

American Home Assurance/FOL
Attn: Katie Foster
Attn: 512.867.1733

[Claimant]