

Parker Healthcare Management Organization, Inc.

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Certificate # 5301

January 23, 2006

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: M2-06-0473-01
RE: Independent review for ____

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

- Parker Healthcare Management received notification of independent review on 12.20.05.
- Faxed request for provider records made on 12.20.05.
- The case was assigned to a reviewer on 1.9.06.
- The reviewer rendered a determination on 1.20.06.
- The Notice of Determination was sent on 1.23.06.

The findings of the independent review are as follows:

Questions for Review

Medical necessity of the requested service gill decompression L-5 spondyloisthesis reduction/posterior fusion L4-S1/ICGB/SOCON reduction system/anterior fusion L4-S1/screws

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 _____. The patient, a 39 year old female, was treated conservatively, neurologically intact, mild tenderness, mild spasm, neurologically intact, adequate gait.

Clinical Rationale

The records indicate the patient fell back sustaining a strain/sprain to the low back and pelvis areas. She sustained a back strain/sprain which should have resolved itself within 6-8 weeks, the spondylolisthesis was noted. It shows per the records the issue of spondylolisthesis being preexisting is undetermined.

The patient was seen by multiple physicians including RME and DD physicians, who stated the patient didn't require additional treatment and was issued a 0% impairment rating. Per the records, the straight leg raising tests were negative, reflexes were normal, motor and sensory exams were normal, and had positive Waddell's testing/signs.

In all medical probability, the patient sustained a strain/sprain in the Lumbar area, which has resolved. Strain/sprains of the Lumbar area usually resolve with or without treatment in 4-6 weeks. At this time, there is no objective clinical reason for further treatment and/or surgical intervention reconstruction or decompression or excision of the Gill lesion. The patient is not a candidate for surgery with normal neurological exam, no documentation of instability and positive Waddell's signs. There is no sound clinical rationale since there is no clinical findings and no instability, surgery is not indicated or warranted.

Clinical Criteria, Utilization Guidelines or other material referenced

- American Medical Association, 4th and 5th edition, Guidelines of Physical Impairment
 - Campbell's Orthopedics
 - The Physician's guide, To Return to Work
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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 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.

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 23rd day of January 2006.

Meredith Thomas
Administrator
Parker Healthcare Management Organization, Inc.

CC:

Richard Francis, M.D.
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Service Lloyds
Attn: Robert Josey
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