

Parker Healthcare Management Organization, Inc.

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Certificate # 5301

March 31, 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: M2-06-0754-01
RE: Independent review for ____

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

- Parker Healthcare Management received notification of independent review on 2.10.06.
- Faxed request for provider records made on 2.10.06.
- TDI-DWC issued an Order for Payment on 2.22.06.
- The case was assigned to a reviewer on 3.16.06.
- The reviewer rendered a determination on 3.30.06.
- The Notice of Determination was sent on 3.31.06.

The findings of the independent review are as follows:

Questions for Review

Prospective work hardening program additional 5 x 2 weeks

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

Patient is a 44-year-old female cafeteria cook for the _____ who, on ____, slipped on a wet floor, twisted and fell onto her left knee. After limited results were obtained following 2-weeks of medical management that included medication and physical therapy, an MRI was performed that revealed meniscal tears. Arthroscopic repair was eventually performed on 10.7.04, followed by post-operative rehabilitation (aquatic), and a designated doctor saw the claimant on 12.16.04, deemed her to be at MMI, and awarded a 4% whole-person impairment.

Clinical Rationale

In this case, the medical records submitted adequately documented that a compensable injury occurred to the claimant's left knee that eventually resulted in a surgical repair. Subsequent to

that surgery, the records also documented that the patient sustained functional deficits related to the injury, and that these deficits were being successfully addressed in all measured areas with a work hardening program. With documentation of improvement in the patient's condition and restoration of function, continued treatment is reasonable and necessary to effect additional gains. Therefore, since the patient still has documented functional deficits, and since the preceding 6-week utilization of this service fulfilled the statutory requirements¹ for medical necessity (the patient obtained relief, promotion of recovery was accomplished and there was an enhancement of the employee's ability to return to her employment), it is reasonable to assume that this claimant will continue to improve for an additional 2 weeks.

In terms of the carrier's denial of this service, their reviewer wrote in his opinion that "...the claimant is currently rated at the Light/Medium physical demand level, and needs to be at the Medium level." Then, a sentence later, he additionally wrote, "There is no compelling rationale submitted to explain medical necessity of work hardening one year status post surgery." To the contrary, the reviewer provided the rationale for medical necessity himself.

Moreover, the reviewer cited the ACOEM guidelines, stating that "Patients with any type of knee injury or disorder will find prolonged standing and walking to be difficult, but return to **modified-duty** [emphasis added] is extremely desirable to maintain activities and prevent debilitation." However, the documentation indicated on several occasions that the employer had no light or modified duty to extend in this case and that they expect the employee to return to work only when she is able to fully fulfill the requirements of her position. Therefore, the reviewer's basis for denial is without foundation.

Clinical Criteria, Utilization Guidelines or other material referenced

- ACOEM Guidelines
- 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.

¹ Texas Labor Code 408.021

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 31st day of March, 2006.

Meredith Thomas
Administrator
Parker Healthcare Management Organization, Inc.

CC: Gabriel Gutierrez, D.C.
Attn: Same
Fax: 713.784.5364

Attn; Renee Kenney
Fax: 512.347.0848