

Parker Healthcare Management Organization, Inc.

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972.906.0603 972.906.0615(fax)
Certificate # 5301

June 5, 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: M2-06-0996-01
RE: Independent review for ____

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

- Parker Healthcare Management received notification of independent review on 5.2.06.
- Faxed request for provider records made on 5.2.06.
- The case was assigned to a reviewer on 5.22.06.
- The reviewer rendered a determination on 6.2.06.
- The Notice of Determination was sent on 6.5.06.

The findings of the independent review are as follows:

Questions for Review

Medical necessity of physical therapy CPT codes 97110, 97530, 97112, 97014, and 97140 for 3X week for 4 weeks = 12 visits

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

Mr. ____ sustained a work related on the job injury on ____ while employed with _____.

Clinical Rationale

The documentation in this case simply does not support the need for skilled therapy. The patient has undergone numerous treatment sessions of therapy without any *significant* objective functional improvement documented. Said another way, there is not sufficient documentation to justify that additional formal therapy would be of any benefit at all to this patient, any more than a home exercise program to focus on functional restoration with the goal simply being to return him to work. There is no

evidence that he has achieved any benefit from the therapy sessions, so why would additional therapy (of the same treatment) be indicated?

Again, it is my professional judgment & opinion that the requested therapy is not evidenced to be medically necessary as it relates to the care of Mr. ____.

Clinical Criteria, Utilization Guidelines or other material referenced

This conclusion is supported by the reviewers' clinical experience as a Physical Therapist with over 5 years of experience.

The reviewer for this case is a Physical Therapist peer matched with the provider that would render the care in dispute, as per the preauthorization request. The reviewer is engaged in the practice of physical therapy 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.

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 5th day of June 2006.

Meredith Thomas
Administrator
Parker Healthcare Management Organization, Inc.

CC: Apple Rehabilitation
Attn: Jessica
Fax: 972.223.6446

First Liberty
Attn; Carolyn Guard
Fax: 574.258.5349
