

Parker Healthcare Management Organization, Inc.

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Certificate # 5301

November 28, 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: M2-07-0145-01

RE: Independent review for ____

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

- Parker Healthcare Management received notification of independent review on 10.17.06.
- Faxed request for provider records made on 10.17.06.
- TDI-DWC issued an Order for Payment on 10.26.06.
- The case was assigned to a reviewer on 11.13.06.
- The reviewer rendered a determination on 11.27.06.
- The Notice of Determination was sent on 11.28.06.

The findings of the independent review are as follows:

Questions for Review

Medical necessity of proposed purchase of IF-4000 Interferential Stimulator

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 case history indicates that this individual has received an on-the-job-injury resulting in a lumbosacral sprain and strain back on _____. The injured worker was treated with conservative measures including physical therapy and at the request of the physician advisor, when IF was recommended for purchase it was negotiated for rental for 3 weeks. During that 3 week time, the physician notes indicates that the patient quit taking Percocet for breakthrough pain and increased function, decreased pain, increased in the ability to perform activities of daily living, and improved range of motion and function overall. For those reasons, it was requested again to be purchased.

Additionally, justification has been provided in the form of clinical research performed at the Pain and Recovery Clinic of Chicago.

Clinical Rationale

This device effectively helps to reduce pain, increase function, and has helped to reduce use of medications and other expensive treatments. While the patient is still taking long acting Opioids such as Avinza, according to the medical records, the patient no longer requires breakthrough pain management with Oxycodone/Percocet. I believe that the documents and records of this patient clearly show a positive effect of pain control, increased function, and increased range of motion and thus warrant purchase of the unit for ongoing pain management.

Clinical Criteria, Utilization Guidelines or other material referenced

This conclusion is supported by the reviewers' clinical experience with over 10 years of patient care.

The reviewer for this case is a Medical Doctor licensed by the Texas State Board of Medical Examiners. The reviewer specializes in Physical medicine and Rehabilitation, 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 28th day of November, 2006.

Meredith Thomas
Administrator
Parker Healthcare Management Organization, Inc.

CC: AmeriMed International
Fax: 972.867.6660

Dallas ISD/ Harris and Harris
Fax: 512.346.2539