

Parker Healthcare Management Organization, Inc.

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Certificate # 5301

February 16, 2007

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: M2-07-0621-01

RE: Independent review for ____

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

- Parker Healthcare Management received notification of independent review on 1.2.07.
- Faxed request for provider records made on 1.2.07.
- TDI issued an Order for Payment on 1.18.07.
- The case was assigned to a reviewer on 2.6.07.
- The reviewer rendered a determination on 2.15.07.
- The Notice of Determination was sent on 2.16.07.

The findings of the independent review are as follows:

Questions for Review

Medical necessity of the proposed post injection therapy

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

The claimant is suffering from a work related injury. He was injured on the date of _____. He is still having pain in the area of the right elbow. Apparently, there was a recent flare up of his condition and on 11-3-06 there was an intra articular injection, along with recommended follow up rehabilitative care after the injection. The follow up care that was requested was post injection PT 3x2 weeks then 2x 1 week for a total of eight requested sessions. The therapy that was requested is listed as therapeutic exercise (97110), neuromuscular reeducation (97112) and massage (97124). The request for post injection therapy was done three weeks after the injection was given.

Clinical Rationale

The claimant had an injection for a flare up of the injured elbow area. There are no documented reasons as to why the claimant could not have performed simple therapeutic procedures at home, especially when the requested services were done three weeks after the injection. The ACOEM guidelines do not support the type of treatment program that is requested, especially one that involves the particular time frames of

therapy in this given situation. Due to the lack of medical necessity being established, the denial is upheld.

Clinical Criteria, Utilization Guidelines or other material referenced

- *Occupational Medicine Practice Guidelines*, Second Edition.
- *The Medical Disability Advisor*, Presley Reed MD

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.

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 16th day of February, 2007.

Meredith Thomas
Administrator
Parker Healthcare Management Organization, Inc.

CC: Dr. Al-Sahli
Fax: 281.333.0442

Pacific Employers
Attn: Kayetta Martin