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Primary Diagnosis	Service being Denied	Billing Modifier	Type of Review	Units	Date(s) of Service	Amount Billed	Date of Injury	DW Cl
x			Prosp	10			x	x

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a X who was injured on X, when X. The claimant was diagnosed with X pain. Treatment included X hours of X. Medications included X. An evaluation on X, documented X. There was continued low back pain. Medications included X. The X was X and the X was X. The previous physical demand level was medium, and the

current physical demand level was also medium. The required physical demand level was X.

**ANALYSIS AND EXPLANATION OF THE DECISION
INCLUDE CLINICAL BASIS, FINDINGS AND
CONCLUSIONS USED TO SUPPORT THE DECISION. IF
THERE WAS ANY DIVERGENCE FROM DWC'S
POLICIES/GUIDELINES OR THE NETWORK'S
TREATMENT GUIDELINES, THEN INDICATE BELOW
WITH EXPLANATION.**

The previous noncertification on X, was due to lack of support exceeding the recommended hours and no clear documentation showing a X was contraindicated. The claimant had repeated the recommended hours of a X. At the conclusion of a program, neither reenrollment nor repetition of the same or of a similar program would be supported for the same injury. The records do not reflect sufficient functional gains in the previous program to warrant X. The request for an X, and X for the X is not certified as medical necessity has not been established.

**A DESCRIPTION AND THE SOURCE OF THE
SCREENING CRITERIA OR OTHER CLINICAL BASIS
USED TO MAKE THE DECISION:**

ACOEM- AMERICAN COLLEGE OF
OCCUPATIONAL & ENVIRONMENTAL MEDICINE
UM KNOWLEDGEBASE

AHCPR- AGENCY FOR HEALTHCARE
RESEARCH & QUALITY GUIDELINES

XX DWC- DIVISION OF WORKERS
COMPENSATION POLICIES OR GUIDELINES

- EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN
- INTERQUAL CRITERIA
- XX MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS
- MERCY CENTER CONSENSUS CONFERENCE GUIDELINES
- MILLIMAN CARE GUIDELINES
- XX ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES
- PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR
- TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS
- TMF SCREENING CRITERIA MANUAL
- PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)