

April 19, 2005

ATTN: Program Administrator
Texas Workers Compensation Commission
Medical Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100
Austin, TX 78744
Delivered by fax: 512.804.4868

Notice of Determination

MDR TRACKING NUMBER: M2-05-1251-01
RE: Independent review for ____

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

- Parker Healthcare Management received notification of independent review on 3.24.05.
- Fax request for provider records made on 3.24.05.
- The case was assigned to a reviewer on 4.14.05.
- The reviewer rendered a determination on 4.18.05.
- The Notice of Determination was sent on 4.19.05.

The findings of the independent review are as follows:

Questions for Review

Prospective medical necessity of the proposed chronic pain management program, 5 times per week for 4 weeks.

Determination

It is my determination to **overturn the denial** for a chronic pain management program.

Summary of Clinical History

Mr. ____ sustained a work-related injury of the lumbar spine on _____. Since his injury he has had some improvement with conservative efforts, but failed his work hardening program and has since deteriorated psychologically. His depression has responded partially to Zoloft but is negatively impacted by cultural factors and psychosocial stressors. A chronic pain management program has been requested to adequately address ineffective coping mechanisms and psychological stressors.

Clinical Rationale

Mr. ____ appears to be an appropriate candidate for a multidisciplinary treatment approach to active and persistent disabling pain complaints complicated by depression and cultural impediments. In response to the arguments supporting denials, it is doubtful that "mental health care" within the context of a working hardening program was "adequate" for the claimant's complicated and worsening depression, and the question of surgical intervention was without clinical bearing on the medical necessity for expedient treatment intervention to prevent further (and more costly) progression of Mr. ____'s disability.

Clinical Criteria, Utilization Guidelines or other material referenced

This conclusion is supported by the reviewers' clinical experience as a Psychiatrist with over 10 years of experience.

The reviewer for this case is a Medical Doctor licensed by the Texas State Board of Medical Examiners. The reviewer is Board Certified in Psychiatry, and is engaged in the full time practice of psychiatric medicine.

The review was performed in accordance with Texas Insurance Code §21.58C and the rules of the Texas Workers Compensation Commission. In accordance with the act and the rules, the review is listed on the TWCC'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 any of the providers or other parties associated with this case. 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.

In accordance with TWCC Rule 102.4 (h), a copy of this decision was sent to the carrier, requestor, claimant (and/or the claimant's representative) and the TWCC via facsimile, U.S. Postal Service or both on this 19th day of April, 2005.

If our organization can be of any further assistance, please feel free to contact me.

Sincerely,

Meredith Thomas
Administrator

CC: Dean McMillian, MD
Attn: Gracie Diaz
Fax: 713.697.7111

[Claimant]

American Interstate Ins. Co
Attn: Stacey Joslin
Fax: 337.463.9079