Parker Healthcare Management Organization, Inc.
3719 N. Beltline Road, Irving, TX 75038
972.906.0603 972.255.9712 (fax)
Certificate # 5301

July 6, 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: M2-05-1791-01
RE: Independent review for ___

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

- Parker Healthcare Management received notification of independent review on 6.02.05.
- Telephone request for provider records made on 6.3.05.
- TWCC issued an Order for Payment 6.14.05.
- The case was assigned to a reviewer on 6.20.05.
- The reviewer rendered a determination on 7.5.05.
- The Notice of Determination was sent on 7.6.05.

The findings of the independent review are as follows:

Questions for Review

Medical necessity of the proposed chronic pain program 5 x 4 weeks

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.

Summary of Clinical History

Ms. ___ sustained a work related injury on ___, while employed with .

Clinical Rationale

The documented duration and degree of the claimant's dysfunction warrant an extensive multimodal pain management program. Individual counseling (alone) would be grossly inadequate to address her global dysfunction. A reasonable treatment plan to taper and discontinue the claimant's narcotic medication was provided (as requested) to Utilization review. Therefore, it is my best medical opinion that a chronic pain management program is reasonable and medically necessary for claimant ___'s clinical condition/situation.

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 and pain management.

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.

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Tex. Admin. Code § 148.3). This Decision is deemed received by you 5 (five) days after it was mailed and the first working day after the date this Decision was placed in the carrier representative's box (28 Tex. Admin. Code § 102.5 (d)). A request for hearing should be sent to: Chief Clerk of Proceeding/Appeals , P.O. Box 17787, Austin, Texas 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request. The party appealing the Division's Decision shall deliver a copy of this written request for a hearing to the opposing party involved in the dispute.

I hereby verify that a copy of this Findings and Decision was faxed to TWCC, Medical Dispute Resolution department, 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 6th day of July, 2005. Per Commission Rule 102.5(d), the date received is deemed to be 5 (five) days from the date mailed and the first working day after the date this Decision was placed in the carrier representative's box.

_____

Meredith Thomas
Administrator
Parker Healthcare Management Organization, Inc.

CC: C.M. Schade, MD
Attn: America Martinez
Fax: 972.494.5224

Downs and Stanford
Attn: W. Jon Grove
Fax: 214.748.4530

[Claimant]