

Parker Healthcare Management Organization, Inc.

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Certificate # 5301

January 31, 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: M2-06-0502-01

RE: Independent review for ____

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

- Parker Healthcare Management received notification of independent review on 1.5.06.
- Faxed request for provider records made on 1.5.06.
- The case was assigned to a reviewer on 1.18.06.
- The reviewer rendered a determination on 1.30.06.
- The Notice of Determination was sent on 1.31.06.

The findings of the independent review are as follows:

Questions for Review

Preauthorization for 30 sessions of chronic pain management.

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

Claimant underwent physical medicine treatments and surgeries after sustaining injury at work on ____.

Clinical Rationale

The previously attempted physical medicine treatments and psychological sessions had within them the self-help strategies, coping mechanisms, exercises and modalities that are inherent in and central to the proposed chronic pain management program. In other words and for all practical purposes, much of the proposed program has already been attempted and failed. Therefore, since the patient is not likely to benefit in any meaningful way from repeating unsuccessful treatments, the chronic pain management program is medically unnecessary.

While not applicable for this claimant, the 1996 TWCC Medical Fee Guideline ¹ nevertheless identified appropriate criteria that must be met for physical medicine treatment to qualify for reimbursement: (1) the patient's condition shall have the potential for restoration of function and (2) the treatment shall be specific to the injury and provide for the potential improvement of the patient's condition. Potential for restoration of function is identified by progressive return to function. Without demonstration of objective progress, ongoing treatment cannot be reasonably expected to restore this patient's function and thus can only be deemed medically unnecessary. According to the Medicare Guidelines ², if a patient's expected restoration potential is insignificant in relation to the extent and duration of the physical medicine services required to achieve such potential, the services would not be considered reasonable or necessary.

Current medical literature states, "...there is no strong evidence for the effectiveness of supervised training as compared to home exercises. There is also no strong evidence for the effectiveness of multidisciplinary rehabilitation as compared to usual care."³ The literature further states "...that there appears to be little scientific evidence for the effectiveness of multidisciplinary biopsychosocial rehabilitation compared with other rehabilitation facilities..."⁴ And a systematic review of the literature for a multidisciplinary approach to chronic pain found only 2 controlled trials of approximately 100 patients with no difference found at 12-month and 24-month follow-up when multidisciplinary team approach was compared with traditional care.⁵ Based on those studies and the medical records supplied in this case, the proposed chronic pain management program is not supported.

Clinical Criteria, Utilization Guidelines or other material referenced

- See footnote below for references utilized.

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.

¹ 1996 TWCC Medical Fee Guideline, Medicine Ground Rules, Section I, A, p. 31.

² Centers for Medicare and Medicaid Services, Carriers Manual Part 3 Chapter II - Coverage and Limitations Rev. 1606 / Page 2-94.11

³ Ostelo RW, de Vet HC, Waddell G, Kerchhoffs MR, Leffers P, van Tulder M, Rehabilitation following first-time lumbar disc surgery: a systematic review within the framework of the cochrane collaboration. Spine. 2003 Feb 1;28(3):209-18.

⁴ Karjalainen K, Malmivaara A, van Tulder M, Roine R, Jauhiainen M, Hurri H, Koes B. Multidisciplinary biopsychosocial rehabilitation for neck and shoulder pain among working age adults. Cochrane Database Syst Rev. 2003;(2):CD002194.

⁵ Karjalainen K, et al. Multidisciplinary rehabilitation for fibromyalgia and musculoskeletal pain in working age adults. Cochrane Database of Systematic Reviews 2000;2.

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 31st day of January 2006.

Meredith Thomas
Administrator
Parker Healthcare Management Organization, Inc.

CC: Cameron Jackson, D.C.
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