

# Parker Healthcare Management Organization, Inc.

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Certificate # 5301

April 10, 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: M2-06-0883-01  
RE: Independent review for \_\_\_\_

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

- Parker Healthcare Management received notification of independent review on 3.13.06.
- Faxed request for provider records made on 3.14.06.
- The case was assigned to a reviewer on 3.29.06.
- The reviewer rendered a determination on 4.7.06.
- The Notice of Determination was sent on 4.10.06.

The findings of the independent review are as follows:

### Questions for Review

Medical necessity of 20 sessions of a Chronic Pain Management program.

### 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** on the requested service(s).

### Summary of Clinical History

The claimant was injured on the date of \_\_\_\_\_. There are multiple areas of injury including his left knee and the lower back with some mention of the right shoulder as well. The claimant has received functional testing, trigger point injections, conservative care, electro diagnostic studies, and advanced imaging as well as multiple consults. In the past there have been scheduled psychiatric evaluations, lumbar surgery, knee surgery and diagnoses of radiculopathy.

### Clinical Rationale

The claimant has significant pain in multiple areas with various areas being post surgical. The claimant has chronic pain that has been persistent despite conservative and various other forms of care. The claimant has clinical findings of depression and difficulty with coping skills. The claimant has anxiety and stress. The claimant has dependency on medications as well to control symptoms. As a result of the

collection of continued symptoms and findings and failed previous care to control symptoms, chronic pain management would be the next logical clinical step or progression in regards to offered or available therapy.

## Clinical Criteria, Utilization Guidelines or other material referenced

- *Occupational Medicine Practice Guidelines*, Second Edition.
- *The Medical Disability Advisor*, Presley Reed MD
- *A Doctors Guide to Record Keeping*, Utilization Management and Review, Gregg Fisher
- Texas Labor Code 408.021
- *DWC Medicine Ground Rules II(g)(1) page 40*

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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 10<sup>th</sup> day of April 2006.

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Meredith Thomas  
Administrator  
Parker Healthcare Management Organization, Inc.

CC: Positive Pain Management  
Attn: Heidi Wilson  
Fax: 972.487.1916

Connecticut Indemnity  
Attn: Tom Lang  
Fax: 512.452.7004

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