

Parker Healthcare Management Organization, Inc.

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972.906.0603 972.255.9712 (fax)

Certificate # 5301

April 17, 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: M2-06-0912-01

RE: Independent review for ____

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

- Parker Healthcare Management received notification of independent review on 3.17.06.
- Faxed request for provider records made on 3.17.06.
- The case was assigned to a reviewer on 4.4.06.
- The reviewer rendered a determination on 4.14.06.
- The Notice of Determination was sent on 4.17.06.

The findings of the independent review are as follows:

Questions for Review

Medical necessity of 20 days of interdisciplinary chronic pain mgmt, 5X WK X 8 hours a day

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 disputed service(s).

Summary of Clinical History

Ms. ____ is a 50 y/o female injured in ____ with multiple Spinal Surgeries, most recently in 2005 with history of chronic back pain. She is on multiple pain medications and has not been able to work for many years.

Clinical Rationale

Based on my review of the clinical information this claimant has completed exhaustive treatment and alternative medical management including multiple surgeries as recently as 2005. She is in need of a tertiary treatment program such as a Chronic Pain Management Program to help address her functional activities, pain medication management and explore any possibilities of increasing her employability.

Clinical Criteria, Utilization Guidelines or other material referenced

This conclusion is supported by the reviewers' clinical experience with over 10 years of patient care.

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

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 17th day of April, 2006.

Meredith Thomas
Administrator
Parker Healthcare Management Organization, Inc.

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Fire & Causality insurance/CO Cunningham Lindsey
Attn: Tom Lang
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