

Parker Healthcare Management Organization, Inc.

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Certificate # 5301

June 14, 2006

TTN: 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: M2-06-1229-01
RE: Independent review for ____

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

- Parker Healthcare Management received notification of independent review on 5.3.06.
- Faxed request for provider records made on 5.3.06.
- TDI-DWC issued an Order for records on 5.16.06.
- The case was assigned to a reviewer on 6.2.06.
- The reviewer rendered a determination on 6.13.06.
- The Notice of Determination was sent on 6.14.06.

The findings of the independent review are as follows:

Questions for Review

Medical necessity of the requested 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 as result of a work related injury on the date of _____. The records reflect that the claimant was injured while carrying a bag of coins that weighed between 20 and 50 pounds. The next day she had cervical spine pain that radiated down in the left shoulder and down into the left hand and fingers. Since the time of the accident that claimant has had examination from various practitioners as well as various forms of advanced diagnostics. The claimant has been given diagnoses that include cervical radiculopathy, chronic pain, myofascitis, left rotator cuff impingement and cervical herniated disc as well as carpal tunnel syndrome.

Clinical Rationale

The claimant was denied as being a surgical candidate by Dr. Arthur Sarris. The claimant has received active care and other forms of conservative treatment and lower level therapy that has failed. The claimant is taking medications to control pain and to control sleep and anxiety and depression. The claimant still has various musculoskeletal findings with range of motion and strength deficits. The claimant has high pain levels on the VAS and significant findings on the psychologic evaluation and BDI and BAI scores and BAP testing that all point to chronic pain management as being a valid option and medically necessary program for the claimant at this point in recovery.

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
 - ODG Guidelines
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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 14th day of June 2006.

Meredith Thomas
Administrator
Parker Healthcare Management Organization, Inc.

CC: Positive Pain Management
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Ace America/ESIS
Attn: Shelley Smith
Fax: 972.465.7964