Parker Healthcare Management Organization, Inc.
4030 N. Beltline Road, Irving, TX 75038
972.906.0603 972.906.0615(fax)
Certificate # 5301

September 27, 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: M2-06-1832-01
RE: Independent review for ___

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

- Parker Healthcare Management received notification of independent review on 8.23.06.
- Faxed request for provider records made on 8.23.06.
- The case was assigned to a reviewer on 9.15.06.
- The reviewer rendered a determination on 9.26.06.
- The Notice of Determination was sent on 9.27.06.

The findings of the independent review are as follows:

Questions for Review

Medical necessity of proposed chronic pain management program, 160 hours

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

Mr. ___ sustained a work related on the job injury on ___, while employed with
.

Clinical Rationale

The previously attempted individual psychological sessions, passive physical therapy, active physical therapy, and partial work hardening program 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 proposed chronic pain management program is unsupported and medically unnecessary.

Clinical Criteria, Utilization Guidelines or other material referenced

- *Occupational Medicine Practice Guidelines*, Second Edition.

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 27th day of September, 2006.

_____
Meredith Thomas
Administrator
Parker Healthcare Management Organization, Inc.

CC: North TX Pain Recovery Ctr
Attn: Tuan Le
817.478.7628

Texas Mutual
Attn: Latreace Giles
512.224.7094