

Parker Healthcare Management Organization, Inc.

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Certificate # 5301

October 18, 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: M2-07-0012-01

RE: Independent review for ____

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

- Parker Healthcare Management received notification of independent review on 9.21.06.
- Faxed request for provider records made on 9.21.06.
- The case was assigned to a reviewer on 10.5.06.
- The reviewer rendered a determination on 10.17.06.
- The Notice of Determination was sent on 10.18.06.

The findings of the independent review are as follows:

Questions for Review

Medical necessity of 20 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

Ms. ____ was allegedly injured on a fall working for Auto Zone as the manager. The injury occurred in ____, injuring her ankle and back. She has had a workup including an MRI of her lumbar spine and back. She has been seen by a spine specialist, Dr. Stephen Esses, who did not feel she had a surgical lesion. She has been told she has lumbar radiculopathy. She has not completed significant lower level treatment including work hardening and physical therapy. She has been denied this by the carrier. She was not allowed to have injections due to her diabetes and it was felt that the steroids would exacerbate her underlying condition. It is now being requested that she have a comprehensive pain management program for an injury occurring in ____.

Clinical Rationale

Chronic pain management is for patients that have failed to achieve progress with traditional conservative treatments. This individual has not completed injection, has not been considered a surgical candidate, has not completed lower level physical therapy or work conditioning program. The fact that these were denied by the carrier does not mean that she is now a candidate for a tertiary treatment program such as chronic pain management. If there is a concern that she may need additional care, it would be most

appropriate for her to proceed with the lower levels of care that have been denied. Therefore, she does not meet the criteria for chronic pain management. She has not completed lower level care in the form of physical therapy and reconditioning program.

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 18th day of October, 2006.

Meredith Thomas
Administrator
Parker Healthcare Management Organization, Inc.

CC: Dean Mcmillan, M.D.

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