

Parker Healthcare Management Organization, Inc.

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972.906.0603 972.906.0615(fax)

Certificate # 5301

October 24, 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: M2-07-0044-01

RE: Independent review for ____

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

- Parker Healthcare Management received notification of independent review on 9.25.06.
- Faxed request for provider records made on 9.25.06.
- The case was assigned to a reviewer on 10.11.06.
- The reviewer rendered a determination on 10.24.06.
- The Notice of Determination was sent on 10.24.06.

The findings of the independent review are as follows:

Questions for Review

Medical necessity of Chronic Behavioral Pain Management program, additional 10 sessions

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 a result of a work related accident. She was reported as opening a barrel and as a result suffered an injury to the lower back. The date of injury is reported as being _____. Since the time of the accident, the claimant has received diagnostic imaging, three surgeries to the lower back, injections as well as conservative active and tertiary care. She was taking medications but apparently due to availability and denial of medications, she was taken off her medications and had a rebound in the mental and physical aspects of her condition and her pain escalated.

Clinical Rationale

The documentation reflects the fact that the claimant has received a significant injury which required multiple surgeries to the lower back. During her course of past treatment it has been documented that she received pain management. The documentation reflects that she improved in many areas from this provided service. More recently, she was taken off of her medication because they were simply denied as being necessary; as a result, she had no apparent options but to discontinue her current medications.

As a result, her anxiety depression and pain increased. Since her medication is not considered an option any longer, another means of management was considered. Since this program had worked in the past, the logical conclusion is that it would be a viable option again. She still has clear medical need for CPM. She has anxiety, depression, hopelessness and other psychological symptoms. There is still pain and her GAF, BDI and BAI reflect the continuation of symptoms that are worthy of being addressable. The recommended care of CPM should be approved.

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
 - *ACOEM Guidelines*.
 - *Labor Code, 408.021*
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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 24th day of October 2006.

Meredith Thomas
Administrator
Parker Healthcare Management Organization, Inc.

CC: Bexar County Healthcare
Attn: Nick Kempisty

Liberty Mutual
Attn: Carolyn Guard