

Parker Healthcare Management Organization, Inc.

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972.906.0603 972.906.0615(fax)

Certificate # 5301

January 24, 2007

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: M2-07-0175-01

RE: Independent review for ____

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

- Parker Healthcare Management received notification of independent review on 12.1.06
- Faxed request for provider records made on 12.1.06
- The case was assigned to a reviewer on 1.9.07
- The reviewer rendered a determination on 1.23.07
- The Notice of Determination was sent on 1.24.07

The findings of the independent review are as follows:

Questions for Review

Preauthorization request for individual psychotherapy 1 x per week for 6 weeks.

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 injury on _____. As a result, there was a sustained injury to the right wrist and hand.

Clinical Rationale

The claimant has a compensable injury to the right wrist. The claimant was assaulted and struck by another employee. Her pain levels are at a 5/10 and when she is active her pain can go up to a 10. Since the accident she has been experiencing appetite changes, nausea, shortness of breath, panic attacks, waking during the night and has to have medications in order to function at all due to pain. She still has documented function loss. She has mood swings, feelings of hopelessness, excessive worry, sadness, crying and poor concentration. She has a BDI-II score of 27 which demonstrates severe depression and a BAI of 11 demonstrating associated anxiety. She has a GAF of 51-60 demonstrating that her symptoms are affecting her ability to recover. It appears that her work injury and the complications from the injury have created or perpetuated her mental and emotional symptoms. There is detailed evidence that demonstrates she has the clear need for psychological care and intervention.

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

CARF Guidelines

The reviewer for this case is a doctor of chiropractic peer matched with the provider that served as the treating doctor. 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 May, 2005.

Meredith Thomas
Administrator
Parker Healthcare Management Organization, Inc.

CC: Requestor: _____

Respondent: Hartford Underwriters Ins.
ATTN: Barbara Sachse
512.343.6836

Patient: _____