

November 18, 2004

David Martinez  
TWCC Medical Dispute Resolution  
MS-48  
7551 Metro Center Drive, Suite 100  
Austin, TX 78744-1609

Patient:  
TWCC #:  
MDR Tracking #: M2-05-0278-01  
IRO #: 5251

Ziroc has been certified by the Texas Department of Insurance as an Independent Review Organization. The Texas Worker's Compensation Commission has assigned this case to Ziroc for independent review in accordance with TWCC Rule 133.308 which allows for medical dispute resolution by an IRO.

Ziroc has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed.

The independent review was performed by a matched peer with the treating doctor. This case was reviewed by a licensed Doctor of Osteopathy board certified in anesthesiology and specialized in chronic pain management. The reviewer is on the TWCC Approved Doctor List (ADL). The Ziroc health care professional has signed a certification statement stating that no known conflicts of interest exist between the reviewer and any of the treating doctors or providers or any of the doctors or providers who reviewed the case for a determination prior to the referral to Ziroc for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

#### RECORDS REVIEWED

Records reviewed include the disputed services; office notes – Dr. R, M.D., 2004; notes – High Point Rehab, 2004; correspondence – Dr. K, M.D., 2004, 03, 04; correspondence, procedure and office notes – Dr. C, M.D., 2004; Impairment rating – Dr. S, D.C., 2001, Dr. B, M.D., 2002; CT report 04/03/02; correspondence – Dr. V, M.D., 06/03/03; procedure note – Dr. F, M.D., 06/26/03; EMG report – Dr. L, M.D.; evaluation report – Dr. D PC; evaluation report – \_\_\_\_.

#### CLINICAL HISTORY

A work-related lifting incident apparently resulted in lumbar injury on \_\_\_\_\_. The patient eventually had lumbar surgery and multiple interventional pain procedures performed. In spite of those measures and continuing medical therapy, a chronic pain syndrome has developed.

#### REQUESTED SERVICE

A multidisciplinary chronic pain management program daily for six weeks is requested for this patient.

## DECISION

The reviewer disagrees with the prior adverse determination.

### BASIS FOR THE DECISION

Review of materials supports the diagnosis of chronic pain syndrome complicating a failed back syndrome. Multiple procedural interventions and continuing medical therapy have not been effective in bringing about a satisfactory resolution. Participation in chronic pain management programs can facilitate improved coping skills, realistic expectations and overall reduction in use of the healthcare system.

Ziroc has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. Ziroc has made no determinations regarding benefits available under the injured employee's policy.

As an officer of ZRC Services, Inc, dba Ziroc, I certify that there is no known conflict between the reviewer, Ziroc and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

Ziroc is forwarding by mail and, in the case of time sensitive matters by facsimile, a copy of this finding to the treating doctor, payor and/or URA, patient and the TWCC.

Sincerely,

President/CEO

### YOUR RIGHT TO REQUEST A HEARING

Either party to medical dispute may disagree with all or part of the decision and has a right to request a hearing.

**If disputing a spinal surgery prospective decision**, a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **10** (ten) calendar days of your receipt of this decision (28 Tex. Admin. Code 142.5(c)).

**If disputing other prospective medical necessity (preauthorization) decisions**, a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **20** (twenty) calendar days of your receipt of this decision (28 Tex. Admin. Code 142.5(c)).

This decision is deemed received by you 5 (five) days after it was mailed or the date of fax (28 Tex. Admin. Code 102.5(d)). A request for a hearing and a **copy of this decision** must be sent to:

Chief Clerk of Proceedings / Appeals Clerk  
P.O. Box 17787  
Austin, Texas 78744  
Fax: 512-804-4011

The party appealing this decision shall deliver a copy of its written request for a hearing to other party involved in this dispute.

Sincerely,

President/CEO

**I hereby certify, in accordance with TWCC Rule 102.4 (h), that a copy of this Independent Review Organization decision was sent to the carrier, requestor, claimant (and/or the claimant's representative) and the TWCC via facsimile, U.S. Postal Service or both on this 18th day of November, 2004.**

**Signature of Ziroc Representative:**

**Name of Ziroc Representative:**