



January 2, 2007

Re: MDR #: M2 07 0440 01 Injured Employee: ___
DWC #: ___ DOI: ___
IRO Cert. #: 5340 SS#: ___

TRANSMITTED VIA FAX TO:

TDI, Division of Workers' Compensation

Attention:

Medical Dispute Resolution

Fax: (512) 804-4868

RESPONDENT: Texas Mutual

TREATING DOCTOR: Gerardo Zavala, MD

In accordance with the requirement for DWC to randomly assign cases to IROs, DWC assigned this case to ZRC Medical Resolutions for an independent review. ZRC has performed an independent review of the medical records to determine medical necessity. In performing this review, ZRC reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

I am the president of ZRC Medical Resolutions, Inc. and I certify that the reviewing physician in this case has certified to our organization that there are no known conflicts of interest that exist between him and 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 Independent Review Organization. Information and medical records pertinent to this medical dispute were requested from the Requestor and every named provider of care, as well as from the Respondent. The independent review was performed by a matched peer with the treating health care provider. Your case was reviewed by a physician who is a board certified in physical medicine/rehabilitation and pain medicine and is currently listed on the DWC Approved Doctor List.

We are simultaneously forwarding copies of this report to all parties to the dispute and the TDI, Division of Workers' Compensation. This decision by ZRC Medical Resolutions, Inc. is deemed to be a DWC decision and order.

P.O. Box 855
Sulphur Springs, TX 75483
903.488.2329 * 903.642.0064 (fax)

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.

I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to the carrier, the requestor and claimant via facsimile or U.S. Postal Service from the office of the IRO on January 2, 2007.

Sincerely,



Jeff Cunningham, DC
President



**REVIEWER'S REPORT
M2 07 0440 01**

MEDICAL INFORMATION REVIEWED:

1. Records from Alta Vista including reports from Annabel Menchaca, Counselor, from 09/15/06
2. Evaluation by Dr. Castillo dated 08/09/06 finding the patient to be at maximum medical improvement with regards to all areas except the low back where he recommended lumbar epidural steroid injections
3. Note on 08/24/06 from Dr. Zavala where he complained of low back and right lower extremity pain down to the heel and was recommended epidural steroid injections
4. Physical performance evaluation reported 07/24/06 finding him to be able to function at a sedentary level
5. Notes from counselor Phil Bohart from Alta Vista Healthcare
6. MRI scan reports as follows: lumbar spine on 04/01/05 finding L4/L5 and L5/S1 bulging discs; MRI scan of the right knee on 05/13/06 finding medial collateral ligament strain; MRI scan of the left wrist on 12/15/05 finding osteoarthritis of the proximal carpal row
7. Request for 20 visits of chronic pain therapy

BRIEF CLINICAL HISTORY:

On ___ the claimant fell 14 feet, landing with his hands outstretched, injuring his back, right knee, and both wrists.

DISPUTED SERVICES:

Twenty visits of pain management services, 5 times per week for 4 weeks.

DECISION:

I AGREE WITH THE DETERMINATION MADE BY INSURANCE CARRIER IN THIS CASE.

RATIONALE OR BASIS FOR DECISION:

It is my belief that this individual does not require 20 visits of chronic pain management. There is no operable condition. There is no indication of a definitive posttraumatic injury by the way of MRI scanning of the lower back, right knee, or left wrist. The only condition for which he has not yet been found to be at maximum medical improvement and for which causation appears to have been established is that of his lumbar spine for which epidural steroid injections have been recommended. This appears reasonable.

However, entering into a chronic pain program for 5 days a week for 4 weeks is not consistent with the diagnosis of a low back strain.

SCREENING CRITERIA/TREATMENT GUIDELINES/PUBLICATIONS UTILIZED:

It is my opinion that he has many negative psychosocial stressors as indicated in the medical records, which point to a diminished likelihood of benefit from chronic pain management. Chronic pain management is appropriate when someone has obtained maximum medical improvement which, to date, this gentleman has not yet obtained.