



SENT TO: Texas Department of Insurance  
Health & Workers' Compensation Network Certification & QA  
Division (HWCN) MC 103-5A  
Via Fax: 512.804.4868

Injured Employee:  
Respondent: Fire & Casualty Ins. Co./American Trust  
Attn: Kim Soukup  
Fax: 214-382-2425

Treating Doctor: Tom Mayer, M.D.  
Fax: 214-351-6546

Date of Decision: 02/01/07

RE: IRO Case #: *M2.07.0664.01*  
Name: \_\_\_\_\_  
Coverage Type: Workers' Compensation Health Care - Non- network  
Type of Review:  
     Preauthorization  
     Concurrent Review  
     Retrospective Review  
Prevailing Party:  
     Requestor  
     Carrier

ZRC Medical Resolutions, Inc. (ZRC) has been certified, IRO Certificate #5340, by the Texas Department of Insurance (TDI) as an Independent Review Organization (IRO). TDI has assigned this case to ZRC for independent review in accordance with the Texas Insurance Code, the Texas Labor Code and applicable regulations.

ZRC has performed an independent review of the proposed/rendered care to determine if the adverse determination was appropriate. In the performance of the review, ZRC reviewed the medical records and documentation provided to ZRC by involved parties.

This case was reviewed by a D.C., D.O., M.S., Board Certified, Chiropractic, Physical Medicine and Rehabilitation, Pain Management. The reviewer has signed a certification statement stating that no known conflicts of interest exist between the reviewer and the injured employee, the injured employee's employer, the injured employee's insurance carrier, the utilization review agent (URA), and any of the treating doctors or other health care providers who provided care to the injured employee, or the URA or insurance carrier health care providers who reviewed the case for a decision regarding medical



necessity before referral to the IRO. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

As an officer of ZRC, I certify that:

1. there is no known conflict between the reviewer, ZRC and/or any officer/employee of ZRC with any person or entity that is a party to the dispute, and
2. a copy of this IRO decision was sent to all of the parties via U.S. Postal service or otherwise transmitted in the manner indicated above on 02/01/07.

**RIGHT TO APPEAL:**

You have the right to appeal the decision by seeking judicial review. This IRO decision is binding during the appeal process.

For disputes other than those related to prospective or concurrent review of spinal surgery, the appeal must be filed:

1. directly with a district court in Travis County (see Labor Code 413.031(m)), and
2. within thirty (30) days after the date on which the decision is received by the appealing party.

For disputes related to prospective or concurrent review of spinal surgery, you may appeal the IRO decision by requesting a Contested Case Hearing (CCH). A request for CCH must be in writing and received by the Division of the Workers' Compensation, Division Chief Clerk, within ten (10) days of your receipt of this decision.

Sincerely,

A stylized, handwritten signature in black ink that reads "jc".

Jeff Cunningham, D.C.  
President/CEO

**REVIEWER REPORT  
M2.07.0664.01**

**DATE OF REVIEW:** 01/30/07

**IRO CASE #:** M2-07-0664-01

**DESCRIPTION OF THE SERVICE OF SERVICES IN DISPUTE:**

Twenty-nine visits of functional restoration pain management



**DESCRIPTION OF QUALIFICATIONS OF REVIEWER:**

D.C., D.O., M.S., Board Certified, Chiropractic, Physical Medicine and Rehabilitation, Pain Management

**REVIEW OUTCOME:**

“Upon independent review, I find that the previous adverse determination or determinations should be (check only one):

Upheld (Agree)

Overturned (Disagree)

Partially Overturned (Agree in part/Disagree in part)

**INFORMATION PROVIDED FOR REVIEW:**

1. Notes from orthopedic surgeon
2. Specific note from 11/09/06 indicating pain levels of 8/10 with regard to his elbows with no surgical condition identified, and the patient was on Talwin at the time
3. Functional Evaluation Summary report of 11/06/06
4. Mental Health Evaluation report of 11/06/06
5. Report dated 10/26/06
6. Report from dated 05/22/06 indicating maximum medical improvement was obtained on 08/23/05
7. MRI reports of the bilateral elbows of 11/24/03, apparently both normal
8. Peer review report from physical medicine and rehabilitation physician on 05/12/06
9. Peer review assessment of 12/22/05
10. Notes pertaining to injection of the right lateral epicondylar region on 06/10/04
11. Orthopedic consultation report of 06/10/04
12. Evaluation report of 10/24/06 finding “only minimal problems with the left elbow” and no objective signs of abnormalities identified.

**INJURED EMPLOYEE CLINICAL HISTORY (Summary):**

This is a 39-year-old male who injured his elbows on \_\_\_\_\_. He subsequently underwent a right lateral epicondylar release with pronator release on 01/26/05 and a left lateral epicondylar release on 06/15/05. He has undergone physical therapy extensively. He has had chiropractic care extensively. He has had MRI scans of both elbows. He has had the aforementioned surgeries. He has had technological assessment. He has been found to be at maximum medical improvement by Dr. DiLiberti on 10/24/06 without any evidence of a surgical lesion or objective signs of abnormalities that he could discern.

**ANALYSIS AND EXPLANATION OF THE DECISION, INCLUDING CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT DECISION:**

It is my belief that the injured employee does not qualify for a functional restoration pain management program based upon the notation of the physicians that have been involved

with his care and case reviews. The comments by the physician suggest that the minimal problems with the patient's elbows and has no objective abnormalities. There is mention of psychiatric and/or psychological issues including depression and anxiety for which he may require psychiatric and/or psychological counseling, but based on the clinical assessment and the objective test results, it is my belief that he does not require a full functional restoration and pain management program.

**DESCRIPTION AND SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE YOUR DECISION:**

*(Check any of the following that were used in the course of your review.)*

- ACOEM-American College of Occupational & Environmental Medicine UM Knowledgebase.
- AHCPR-Agency for Healthcare Research & Quality Guidelines.
- DWC-Division of Workers' Compensation Policies or Guidelines.
- European Guidelines for Management of Chronic Low Back Pain.
- Interqual Criteria.
- Medical judgement, clinical experience and expertise in accordance with accepted medical standards.
- Mercy Center Consensus Conference Guidelines.
- Milliman Care Guidelines.
- ODG-Official Disability Guidelines & Treatment Guidelines.
- Pressley Reed, The Medical Disability Advisor.
- Texas Guidelines for Chiropractic Quality Assurance & Practice Parameters.
- Texas TACADA Guidelines.
- TMF Screening Criteria Manual.
- Peer reviewed national accepted medical literature (provide a description).
- Other evidence-based, scientifically valid, outcome-focused guidelines (provide a description.)