



## IMED, INC.

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### IRO REVIEWER REPORT

**DATE OF REVIEW:** 03/08/07

**IRO CASE NO.:**

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

Bilateral Trochanteric Bursa Injection  
Cervical Epidural Steroid Injection #1

**A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THIS DECISION:**

Texas License and currently on TDI DWC ADL.  
Board Certified in Anesthesiology and Pain Medicine

**REVIEW OUTCOME:**

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

Upheld.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW:**

1. 09/19/02 – Management.
2. 08/19/04 – Center radiology, MRI cervical spine.
3. 09/09/04, 03/03/05 – Management follow-up notes.
4. 04/05/05 – Center.
5. 05/19/05 – Management follow-up notes.
6. 08/16/05 – Center.
7. 09/09/05 to 09/22/05 – Management follow-up notes.
8. 10/11/05 – Center
9. 12/19/05, 01/19/06, 02/16/06 – Management follow-up notes.
10. 04/04/06 – Center.
11. 04/27/06 to 02/15/07 – Multiple records, Management.
12. 01/24/07, 02/05/07, 02/07/07 – non-certification.

13. 03/06/07 – Fax

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**PATIENT CLINICAL HISTORY (SUMMARY):**

I have reviewed information provided by Dr. and the carrier regarding this employee who had an injury. The records indicate the employee has a history of cervical degenerative disc disease status post fusion with cervical stenosis with bilateral cervical radicular pain, lumbar degenerative disc disease status post fusion, with a history of peptic ulcer disease.

The medical records reviewed indicate treatment status post surgery by Dr. The employee has been prescribed medications.

The employee was referred for a cervical epidural steroid injection and hip trochanteric bursa injection on 11/16/06. These have been denied.

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

The medical information from the treating provider indicated the employee had a clinical examination that revealed “normal vital signs, no apparent distress, employee prefers to extend from the back and leg pain”. Otherwise, there was no significant neurologic or clinical examination findings which would support the recommendations by Dr. There was no documentation of any radiculopathy either objectively on clinical examination or by electrophysiologic data. There was also no physical examination finding which are consistent with trochanteric bursitis. There also does not appear to be any relationship to the compensable injury and these particular recommendations, especially the trochanteric bursitis.

Therefore, using *Official Disability Guidelines*, I cannot support the recommendations requested by Dr. based on lack of specific medical documentation supporting the necessity of these injections.

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

*Official Disability Guidelines*