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## Notice of Independent Review Decision

**DATE OF REVIEW:** 02/04/09

**IRO CASE #:**

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

Nerve root block at L4/L5 level; 72100 x1 spinal x-rays, 77003 x1 x-ray, 64483 x  
1 injection, 20553 x1 trigger point.

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

Board Certified in Orthopedic Surgery

**REVIEW OUTCOME**

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

- Upheld (Agree)
- Overturned (Disagree)
- Partially Overturned (Agree in part/Disagree in part)

Provide a description of the review outcome that clearly states whether or not  
medical necessity exists for each of the health care services in dispute.

Nerve root block at L4/L5 level; 72100 x1 spinal x-rays, 77003 x1 x-ray, 64483 x  
1 injection, 20553 x1 trigger point.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

A Notice of Employee's Work-Related Injury form dated 07/22/08

An evaluation with D.C. dated 07/25/08

Chiropractic therapy with Dr. dated 07/28/08, 07/30/08, 08/01/08, 08/04/08, 08/06/08, 08/08/08, 08/13/08, 08/15/08, 08/18/08, 08/20/08, 08/22/08, 08/25/08, 08/27/08, 08/29/08, 09/03/08, 09/05/08, 09/08/08, 09/10/08, 09/22/08, 09/26/08, 09/29/08, 10/01/08, 10/03/08, 10/06/08, 10/15/08, 10/20/08, 10/21/08, 10/22/08, 10/23/08, 10/27/08, 10/30/08, 10/31/08, 11/05/08, 11/14/08, 11/18/08, 11/21/08, 11/24/08, 12/01/08, 12/08/08, 12/11/08, and 12/18/08

Evaluations with M.D. dated 08/01/08, 09/05/08, 10/24/08, 11/14/08, and 12/11/08

PLN-11 forms filed by the insurance carrier dated 08/25/08, 09/08/08, and 09/16/08

An MRI of the left shoulder interpreted by M.D. dated 08/29/08

A Designated Doctor Evaluation with M.D. dated 10/11/08

A procedure note from Dr. dated 10/13/08

An EMG/NCV study interpreted by Dr. dated 11/12/08

Letters of non-authorization according to the Official Disability Guidelines (ODG), dated 01/09/09 and 01/19/09

A request for reconsideration from Dr. (no credentials were listed) dated 01/12/09

## **PATIENT CLINICAL HISTORY**

Chiropractic therapy was performed with Dr. from 07/25/08 through 12/18/08 for a total of 41 sessions. On 08/01/08, Dr. recommended an MRI of the left shoulder, Lodine XL, Elavil, and bilateral SI joint injections. On 08/25/08, the insurance carrier disputed the treatment of diabetes since it was felt to be a preexisting condition. An MRI of the left shoulder interpreted by Dr. on 08/29/08 was unremarkable. On 09/08/08, the insurance carrier disputed the treatment of depression since it was felt to be a preexisting condition. On 09/16/08, the insurance carrier also disputed a lumbar disc disorder due to an ordinary disease of life. On 10/11/08, Dr. felt the claimant was not at Maximum Medical Improvement (MMI) at that time. An SI joint injection was performed by Dr. on 10/13/08. An EMG/NCV study interpreted by Dr. on 11/12/08 revealed evidence suggestive of a component of mostly chronic radiculopathy on the right at L4-L5. On 01/09/09 and 01/19/09, wrote letters of non-authorization for selective nerve root blocks at L4-L5.

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

This claimant has not received the optimum workup to justify injection therapy to his spine. The claimant is complaining of back pain and is not complaining of pain that radiates down his leg in a radicular fashion. The claimant does not have an MRI of the lumbar spine. It has not been documented that there is a compressive lesion that would be causing radiculopathy. Electrodiagnostic studies alone are not sufficient, according to common sense, common textbooks, and the ODG do document radiculopathy. In the absence of a documented lesion, a fluoroscopic injection is neither reasonable, nor necessary.

The claimant's diagnoses include lumbar sprain/strain, cervical sprain/strain, left shoulder sprain/strain, and a buttock contusion, according to the designated doctor's evaluation. The designated doctor was unable to find any physical abnormalities. This occurred on 10/11/08. Therefore, there is no medical justification to proceed with invasive treatments.

It should be noted that the treating physician, Dr. attempted to overturn one of the adverse determinations by stating he did not know who the reviewing provider was. I will state for the record that I have no relationships with any of the treating providers, nor have I treated the claimant. This independence is certified by the IRO.

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

- ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE AND KNOWLEDGE BASE**
- 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 NATIONALLY ACCEPTED MEDICAL LITERATURE  
(PROVIDE A DESCRIPTION)**
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME  
FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**