

# Parker Healthcare Management Organization, Inc.

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## Notice of Independent Review Decision

**DATE OF REVIEW:** FEBRUARY 20, 2012

**IRO CASE #:**

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

Medical necessity of the proposed a selective nerve block at right L3, right (64483, 72275-26)

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

This case was reviewed by a Medical Doctor licensed by the Texas State Board of Medical Examiners. The reviewer specializes in Physical Medicine and Rehabilitation and is engaged in the full time practice of medicine.

### **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)

Primary Diagnosis	Service being Denied	Billing Modifier	Type of Review	Units	Date(s) of Service	Amount Billed	Date of Injury	DWC Claim#	IRO Decision
724.4	64483		Prosp	1			4.2.11	YZSC04664	Upheld
722.2	72275	26	Prosp	1			4.2.11	YZSC04664	Upheld

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

Request for an IRO- 17 pages

Respondent records- a total of 54 pages of records received to include but not limited to: letter 1.30.12; Request for an IRO forms; letters 12.28.11, 1.12.12; MRI Rt Knee 5.11.11; records 8.30.11-10.10.11; report 9.28.11; MRI Lumbar Spine 9.15.11; 10.11.11-11.10.11

Respondent records- a total of 40 pages of records received from the Carrier to include but not limited to: 10.11.11; MRI Rt Knee 5.11.11; records 8.30.11-10.10.11; records 7.26.11- 9.30.11; MRI Lumbar Spine 9.15.11; form 1; notes 4.4.11-4.13.11; note 5.9.11; note 5.18.11

Requestor records- a total of 29 pages of records received to include but not limited to: letter 1.30.12; 10.11.11-1.26.12; MRI Rt Knee 5.11.11; records 8.30.11-10.10.11; MRI Lumbar Spine 9.15.11

### **PATIENT CLINICAL HISTORY [SUMMARY]:**

The medical records presented for review begin with the initial non-certification of the above noted request and the reconsideration for this non-certification. It is noted that the mechanism of injury was a twisting event. There was low back pain and lower extremity complaints associated with right eye numbness. There was decreased sensation to the right side on physical examination and the patellar reflex was noted as 1+. There was no disc herniation on enhanced imaging or evidence of a radiculopathy. Accordingly, the epidural steroid injection reconsideration was not certified.

The clinical progress note on April 4, 2011, reports the chief complaint of right knee pain. It was noted that the claimant was carrying some items and heard a pop in her knee. It is also noted that the claimant noted an increase in depression and wanted to increase the amount of the medications being prescribed for that malady. The assessment was backache, essential hypertension, and pain in the right knee unspecified. The follow-up physical examination noted a right burning thigh. No specific physical examination was noted other than this is a 5' 5", 230 pound individual.

An additional orthopedic evaluation was completed by an MRI of the knee was ordered.

also completed an orthopedic consultation and noted medial joint line narrowing on plain x-rays associated with lateral tibial plateau osteophytes and spurring of the patella. The assessment was degenerative joint disease right knee, chondromalacia patella right knee, and torn medial gastrocnemius tendon right knee. This was treated with a steroid injection; physical therapy was also initiated.

On August 30, 2011, there was a presenting complaint of low back pain. The evaluation was completed by Stephen Walker, OPAC. Evaluation included plain films of the lumbar spine showing anterior spur at the L4/5 interspace. The assessment was trochanteric bursitis on the left, lumbar radiculopathy, and lumbar back pain; this was treated conservatively. A steroid injection into the right knee was performed on September 30, 2011.

In October, completed an initial evaluation. The low back pain complaints are noted. The assessment was low back pain with a possible lateral disc protrusion. The September 15, 2011, lumbar spine MRI noted osteophyte changes at L2/3, L3/4, L4/5, and a normal disc L5/S1. There was minimal flattening of the thecal sac, a 2 mm disc protrusion at L3/4 and degenerative facet joint changes. No acute pathology was objectified.

The next progress note presented for review is dated January 26, 2012. noted that a selective L3 nerve root injection for diagnostic purposes, sought as the electrodiagnostic study did not show any active axonal loss. However, there were clinical signs of the L3 nerve root irritation based on the disc osteophyte complex at that level. There are ongoing complaints of pain identified. The physical examination noted the claimant to be 5' 5", 240 pounds, borderline hypertensive (130/75) with a pulse rate of 94. The assessment was "presumed right L3 radicular syndrome". Physical therapy had been completed and a chiropractic evaluation was sought to address the low back complaints.

The electrodiagnostic study did not identify any radiculopathy or distal peripheral neuropathy. There was some suggestion of radiculitis.

**Analysis and Explanation of the DECISION INCLUDE clinical basis, Findings and Conclusions Used to Support the Decision. If there was any divergence from DWC's policies/guidelines or the network's treatment guidelines, then indicate below with explanation.**

**RATIONALE:**

As noted in the Division mandated Official Disability Guidelines, review of the treatment plan parameters; without radiculopathy, ODG does not endorse any type of action therapy. Specifically as noted in this section, therapeutic injections of this nature are "not recommended". When considering the findings noted on MRI and the reported mechanism of injury, there is no clear clinical indication presented to suggest or support the treatment plan outlined.

**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 UM KNOWLEDGEBASE
- AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES
- XX DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES
- EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN
- INTERQUAL CRITERIA
- XX MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS
- MERCY CENTER CONSENSUS CONFERENCE GUIDELINES
- MILLIMAN CARE GUIDELINES
- XX 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)