



## **IMED, INC.**

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### **NOTICE OF INDEPENDENT REVIEW**

**NAME OF EMPLOYEE:**  
**IRO TRACKING NUMBER:** M2-06-1977-01  
**NAME OF REQUESTOR:** Injured Employee  
**NAME OF CARRIER:** Texas Mutual Insurance Company  
**DATE OF REPORT:** 10/02/06  
**IRO CERTIFICATE NUMBER:** 5320

#### **TRANSMITTED VIA FAX:**

IMED, Inc. has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO).

In accordance with the requirement for TDI to randomly assign cases to IROs, TDI has assigned your case to IMED, Inc. for an independent review. The peer reviewer selected has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, the peer reviewer reviewed relevant medical records, any documents utilized by the parties referenced above in making the adverse determination, and any documentation and written information submitted in support of the appeal.

The independent review was performed by a matched peer with the treating physician. This case was reviewed by a chiropractic physician reviewer who is Board Certified in the area of Chiropractic Medicine and is currently listed on the DWC approved doctor list.

I am the Secretary and General Counsel of IMED, 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 provider, the injured employee, 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. I further certify that no conflicts of interest of any nature exist between any of the aforementioned parties and any director, officer, or employee of IMED, Inc.

#### **REVIEWER REPORT**

I have reviewed the records forwarded on the above injured worker and have answered the questions submitted.

**Information Provided for Review:**

1. Texas Mutual Insurance Company letter of dispute dated 09/28/06
2. Lamb Healthcare Center x-ray report dated 10/17/03
3. HealthSouth lumbar MRI dated 01/20/05
4. Designated Doctor Evaluation dated 03/10/05, A. Bangale, M.D., designated doctor narrative report
5. Merritt Chiropractic narrative of 04/05/04
6. Merritt Chiropractic narrative of 05/04/04
7. Merritt Chiropractic narrative of 06/30/04
8. Merritt Chiropractic narrative of 08/12/04
9. Merritt Chiropractic narrative of 10/18/04
10. Merritt Chiropractic narrative of 09/17/04
11. Merritt Chiropractic narrative of 01/03/05
12. Merritt Chiropractic narrative of 02/04/05
13. Merritt Chiropractic narrative of 03/14/05
14. Merritt Chiropractic narrative of 04/27/05
15. Merritt Chiropractic narrative of 08/24/05
16. Lubbock Diagnostic Testing Center, Functional Capacity Evaluation dated 02/02/06
17. D. Golovko, M.D., narrative of 04/18/06
18. D. Hagstrom, M.D., operative report dated 04/20/06
19. D. Hagstrom, M.D., office note of 07/10/06
20. Texas Mutual Insurance Company, letter of 07/14/06
21. Texas Mutual Insurance Company, letter of 08/01/06
22. Merritt Chiropractic narrative of 08/18/06

**Clinical History Summarized:**

The employee's injury occurred on or around \_\_\_\_\_. The employee was originally employed by \_\_\_\_\_ and his injury occurred when the machine he was working on broke. This apparently caused it to throw two 20 pound spacers, which struck him in the left anterior pelvic and groin region, as well as the anterior medial aspect of the thigh on the left side. The employee then stated he was thrown back off of a step, which was approximately 4 feet high. He initially stated he was thrown to the ground and, therefore, was also complaining of low back pain.

The employee's initial treatment included an emergency room visit where radiographs were taken confirming absolutely no fractures. Approximately three days after the injury or on or around \_\_\_\_\_, the employee was seen by a family practice physician, Dr. Klein. This physician recommended physical therapy for up to four visits and he provided Darvocet for pain.

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Dr. Qubty was next consulted on 11/05/03. This consultation was for pain management and the employee underwent two sets of nerve root injection. The employee indicated at that time that the injections provided some benefit.

An MRI study performed in 2003 did reveal some scrotal fluid, but otherwise this was a negative evaluation of the pelvis. On 11/06/03, an ultrasound of the left groin and abdomen, as well as at the thigh also showed some swelling of the left proximal thigh in the inguinal area, with some enlargement of the groin musculature and proximal quadriceps. This was consistent with a hematoma, but no hernia was noted.

Records next indicate that the employee was referred for lower extremity EMG study on 11/18/03. The evaluation at that time confirmed no abnormalities.

Eventually, the employee began treating with Dr. Merritt for chiropractic care starting on or around 04/05/04. At the time of the chiropractic evaluation, the employee's primary complaint was that of left hip and groin pain. The pain level was documented as radiating from the lumbar spine into the left hip region, and into the groin. The pain was rated 8/10. Furthermore, at the time of the initial chiropractic evaluation, he was documented as having some type of erectile dysfunction.

Chiropractic evaluation revealed the employee was a 44 year old male who appeared to be in acute distress. He had an antalgic altered gate and he was using a crutch. Moderate muscle spasms were apparently noted bilaterally in the L3 through L5 regions of the lumbar spine and there was apparently some type of active guarding with active trigger points in the left iliolumbar ligament region. Orthopedic testing revealed a positive straight leg raise on the left at approximately 30 degrees, indicating some form of sacroiliac joint irritation. Valsalva maneuver was also considered to be positive.

Neurologically, the employee had normal deep tendon reflexes, but there was some hypoesthesia on the left noted at the L4 region. Manual muscle testing revealed some diminished strength on the left at 4/5 strength in the tibialis anterior and extensor hallucis longus.

Range of motion testing in the lumbar spine revealed a decreased lumbar flexion at 30 degrees, 15 degrees of extension, 20 degrees of right lateral flexion, and 15 degrees of left lateral flexion.

The chiropractic doctor diagnosed left hip and groin sprain/strain, along with some form of radiculitis in the left lower extremity. Furthermore, the diagnosis of erectile dysfunction was provided.

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Chiropractic treatment was to consist of manipulation, adjunctive therapy, and a referral to an urologist. Off work status was also provided.

One month later, on 05/04/04, Dr. C. Merritt again evaluated the employee. No significant changes were noted. The employee still had an antalgic gait and he was utilizing a crutch. Palpation still revealed moderate muscle spasms bilaterally from L3 to L5 and there was an active trigger point in the left iliolumbar ligament. Straight leg raise was now positive at 35 degrees on the left, but the employee still had hypoesthesia of the left L4 dermatome, along with muscle weakness in the left tibialis anterior and extensor hallucis longus. Range of motion was unchanged at 30 degrees of flexion, 15 degrees of extension, 20 degrees of right lateral flexion, and 15 degrees of left lateral flexion. Nevertheless, Dr. Merritt suggested the need for ongoing care despite the fact that the clamant had previously undergone at least eight weeks of physical therapy and rehabilitation for the injury prior to ever entering the chiropractic office.

By 06/30/04, Dr. Merritt again confirmed no change in subjective complaints and no change in objective findings. Nevertheless, ongoing chiropractic care was recommended.

On 08/12/04, the primary complaint was that of left hip pain, low back pain, and groin pain. Pain was now listed as 6/10, but objectively there were only minimal changes. Flexion was now noted to be 35 degrees, but all other findings were exactly the same as four months previously.

During a 10/18/04 office visit, Dr. Cotton suggested the employee's pain level was now 4-6/10. Objectively, range of motion was listed as 35 degrees of flexion, 15 degrees of extension, 15 degrees of right lateral flexion, and 15 degrees of left lateral flexion. The employee also had a positive straight leg raise now at 40 degrees.

Dr. Merritt suggested in October of 2004 that the employee may have a disc herniation in the lumbar spine. He was recommending a lumbar spine MRI study.

By 01/03/05, the employee's pain level had apparently stabilized at a 6/10 level. Objectively, he was still stable with a straight leg raise at 40 degrees, with range of motion stable at 35 degrees of flexion, 15 degrees of extension, 15 degrees of right lateral flexion, and 15 degrees of left lateral flexion. Nevertheless, an MRI was still being recommended.

On 02/04/05, Dr. Merritt suggested the need for a follow-up and/or repeat NCV with EMG study.

A report dictated on or around 03/10/05 by A. Bengale, M.D., suggested a Designated Doctor Evaluation was performed on that date. At that time, Dr. Bengale suggested that MMI had been

reached and he awarded an extensive 17% whole person impairment rating for subjective complaints of pain, as well as erectile dysfunction.

On 03/14/05, Dr. Merritt also saw the employee and he now indicated that he was placing the employee on an as needed schedule.

Dr. Merritt wrote a letter on 04/27/05 suggesting that he was apparently attempting to refer the employee to Dr. Telphenia for a neurosurgical consultation. Instead, the employee was referred to Dr. LeGrand. The remainder of this letter was indicating that physicians in the Lubbock area were no longer accepting workers' compensation due to apparent payment problems.

A narrative dated 08/24/05 from Dr. Merritt again suggested the employee had a pain level of 6/10. Range of motion was now significantly improved since the employee had not been treating with the chiropractor. Range of motion was up to 40 degrees of flexion, 20 degrees of extension, 20 degrees of right lateral flexion, and 20 degrees of left lateral flexion. Additionally, straight leg raise was now only positive 60 degrees on the left, suggesting considerable improvement since chiropractic care had been discontinued.

A Functional Capacity Evaluation (FCE) was apparently performed on 02/02/06. The job activities were suggested to consist of lifting up to 50 pounds on an occasional basis. The actual test results suggested an ability to lift less than 10 pounds on an occasional basis. Dr. Cotton Merritt performed this evaluation and suggested the employee's inability to lift any significant amount of weight was due to subjective complaints of pain.

A narrative report from Dr. Golovko was dated 04/18/06. At this point, this physician performed a Required Medical Evaluation (RME) and he noted a 46 year old male, who had subjective complaints, which were out of proportion with the observed objective findings. Dr. Golovko indicated a lumbar spine MRI was performed on 01/20/05 and this revealed only minimal facet hypertrophy at L3-L4, with moderate degenerative disc disease from T12 through S1. No acute or traumatic structural pathology, including herniated disc was identified.

Dr. Golovko also documented in his records that Dr. LeGrand did evaluate the employee on 02/25/05 and this neurosurgeon suggested that "I do not feel that the etiology of his pain is from his lumbar spine. He did not have the history, the physical examination, or MRI evidence of any type of lumbar spine problems, specifically herniated disc or significant stenosis".

Dr. Golovko went onto document multiple subjective complaints of pain with refusal of testing in certain areas. The employee was, however, to have a completely negative straight leg raise in the seated position.

Dr. Golovko did indicate in his evaluation that the employee apparently had a diagnosis of pain disorder, which was a purely or predominantly psychological condition. He suggested the employee return to work in at least a sedentary position.

It appeared the employee was seen by D. Hagstrom, M.D., on or around 04/20/06. At this point, a cryotherapy lesioning of the left inguinal and left lateral femoral cutaneous nerve was performed.

By 07/10/06, Dr. Hagstrom performed a reevaluation and it was noted that the employee now had severe spasms in the left groin, along with a new diagnosis of neuralgia paraesthetica on the left, with a diagnosis of ilioinguinal nerve entrapment.

A repeat request for caudal epidural steroid injection (ESI) and cryoneurolysis treatment was now being reviewed by the insurance carrier. As of 07/14/06, the initial review was denied stating that the findings of facet arthropathy do not respond to lumbar ESIs. Additionally, the cryoneurolysis treatment of the peripheral nerves mentioned above apparently provided no significant long-term relief and there was also no withdrawal of medication treatment to determine if there was any true efficacy of the prior cryotherapy treatments.

Another letter from the insurance company was dated 08/01/06. At this point, the denial was based on the fact that the employee had degenerative disc disease in the lumbar spine, but it was the opinion of the reviewer at that time that there were no records indicating that nerve blocks of the appropriate nerves had been blocked with local anesthetic with demonstration of short-lived pain relief and, therefore, the request for cryotherapy was not supported as having any better efficacy than a local anesthetic injection.

The most recent narrative report from Dr. C. Merritt was dated 08/18/06. At this point, the employee still had a positive straight leg raise at 60 degrees, with hypoesthesia of the left L4 dermatome. Active range of motion was now listed as 45 degrees of flexion, 20 degrees of extension, 20 degrees of right lateral flexion, and 20 degrees of left lateral flexion. Flexion of the hip was now listed as 80 degrees. The treatment plan at that point was to continue with pain management.

**Disputed Services:**

Items in Dispute: Preauthorization request: Caudal ESI, cryoneurolysis treatment.

**Decision:**

Denial upheld.

**Rationale/Basis for Decision:**

With regard to the request for the caudal ESI, this was denied. According to the *Official Disability Guidelines (ODG)*, ESIs are only recommended as an option for treatment of radicular pain. The criteria for this treatment included radiculopathy that must be documented by physical exam and it must be corroborated by imaging studies, as well as electrodiagnostic testing. This employee has had both electrodiagnostic testing and a lumbar spine MRI, which confirmed no evidence of disc herniation or other physical causes of “radiculopathy”. Furthermore, the physical examinations by both of the physicians in this case did not identify any significant focal neurologic deficits. Finally, an ESI would not be an appropriate form of care for a degenerative disc disease for facet irritation.

The request for cryoneurolysis was also denied. An indication for cryotherapy, including Codman, MD Consultants, Medline, and National Guidelines Clearinghouse sponsored by The Agency for Healthcare Research and Quality found no current guidelines to support the use of this form of care. Additionally, in reviewing other forms of nerve blocks, the consensus criteria suggested that the treatment in question must have a longer effect than the goal standard of a local anesthetic injection. As previously documented in the peer review denial request of 08/01/06, the previous 04/20/06 cryotherapy operative report and/or follow-up report did not confirm that a local anesthetic block was attempted for comparison. Based on the current information, the previous denial for the epidural steroid injection and the cryoneurolysis was upheld.

The rationale for the opinion stated in this report is based on the record review, as well as the broadly accepted literature to include numerous textbooks, professional journals, nationally recognized treatment guidelines and peer consensus.

This review was conducted on the basis of medical and administrative records provided with the assumption that the material is true and correct.

This decision by the reviewing physician with IMED, Inc. is deemed to be a DWC decision and order.

**YOUR RIGHT TO REQUEST A HEARING**

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

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appeal to District Court must be filed not later than thirty (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. A request for a hearing should be faxed to 512-804-4011 or sent to:

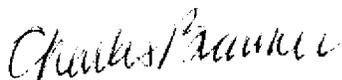
Chief Clerk of Proceedings/Appeals Clerk  
TDI-Division of Workers' Compensation  
P.O. Box 17787  
Austin, TX 78744

A copy of this decision should be attached to the request. The party appealing the decision shall deliver a copy of its written request for a hearing to all other parties involved in this dispute.

If you are disputing the 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 thirty (30) days after the date on which the decision that is the subject of the appeal is final and appealable.

I hereby verify that a copy of this Independent Review Organization's decision was sent to the respondent, the requestor, DWC, and the injured worker via facsimile or U.S. Postal Service this 3<sup>rd</sup> day of October, 2006 from the office of IMED, Inc.

Sincerely,



Charles Brawner  
Secretary/General Counsel

CB/ai