



# IMED, INC.

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## Notice of Independent Review Decision

**DATE OF REVIEW:** 02/24/11

**IRO CASE NO.:**

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

Item in dispute:

64520 Lumbar Sympathetic Block, Left  
77003 Fluoroscopy  
99144 Moderate Sedation

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

Texas Board Certified Physical Medicine & Rehabilitation  
Texas Board Certified Pain Management

**REVIEW OUTCOME**

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

Denial Upheld

**PATIENT CLINICAL HISTORY (SUMMARY):**

The employee is a xx year old female who sustained an injury when she slipped and fell, landing on her left side.

The employee saw Dr. in 11/05. The employee stated she landed on her left proximal forearm, both wrists, and left knee. Physical examination revealed mild patellar tenderness of the left knee. There was diffuse tenderness of the bilateral wrists with slight loss of flexion and extension. Radiographs of the bilateral wrists were negative. The employee was assessed with bilateral wrist contusion and elbow contusion.

The employee was seen for follow up in 12/05. The employee had continued pain complaints. Physical examination revealed full range of motion of the left knee. Examination of the left wrist revealed minimal swelling. There was no ecchymosis or erythema. There was full range of motion. Examination of the right wrist revealed no tenderness. There was no ecchymosis noted. The employee was assessed with wrist

contusion and knee contusion.

Electrodiagnostic studies performed 02/27/06 were abnormal, with evidence of severe median neuropathies at the wrists bilaterally, worse on the right side. An MRI of the left knee performed 02/27/06 demonstrated thickening of the PCL, suggesting PCL strain without tear. The lateral collateral ligamentous complex was normal. Medially, periligamentous edema was appreciated, indicative of MCL strain. There was fluid along the pes anserinus tendon insertion, concerning for pes anserinus bursitis. There was also some fluid paralleling the deep portions of the MCL, which may be related to MCL strain. The lateral meniscus was intact. Medially, there was an inferiorly surfacing tear of the posteromedial corner of the medial meniscus. There was more diffuse mucoid degeneration throughout the posterior horn medial meniscus.

The employee underwent right wrist tenosynovectomy and right carpal tunnel release on 06/26/06. The employee underwent arthroscopic chondral debridement with multiple drilling of the left medial femoral condyle, arthroscopic excision of multiple compartment hypertrophic synovitis of the left knee, and arthroscopic partial medial meniscectomy of the left knee on 08/29/06. The employee completed thirty-four sessions of physical therapy from 07/11/06 through 01/26/07.

The employee underwent left total knee replacement with computer-assisted navigation of the left total knee on 10/10/07. Electrodiagnostic studies performed 03/10/08 revealed an absence of the left median mid palm potential. There was absence of the left median sensory nerve action potential at the mid palm, wrist, and elbow. There was reduced amplitude of the right ulnar sensory nerve action potential amplitude when compared to the left side amplitude. Potentials are absent along the right median nerve and along both the right and left ulnar nerves.

The employee underwent forty-seven sessions of physical therapy from 10/30/07 through 04/04/08.

The employee underwent left carpal tunnel release on 04/22/08.

The employee was seen for psychological evaluation on 07/14/08. The employee complained of pain rating 8 out of 10. The employee reported sleep disturbance secondary to knee pain. The employee's GAF score was 75. The employee was assessed with pain disorder associated with both psychological factors and a general medical condition. The employee was recommended for weekly individual psychotherapy sessions.

The employee attended nine physical therapy sessions from 05/23/08 through 09/25/08.

The employee attended individual therapy from 08/07/08 through 10/10/08.

The employee saw Dr. on 03/12/09. The employee reported significantly increased burning and sensitivity in the left knee. The employee noted occasional color changes in the skin of the left and occasional swelling. Physical examination revealed tenderness to palpation in the anterior medial aspect of the left knee. The skin appeared normal with edema. There was good range of motion. There was some dysesthesia on the anterior medial aspect of the left knee as well as a burning aspect to her symptoms with light touch. The employee was assessed with pain in the lower leg joint. The employee was prescribed Lyrica, Hydrocodone, and Voltaren. The employee was recommended for a therapeutic lumbar sympathetic block.

The employee was seen for follow up on 08/11/09. The employee had continued pain complaints, as well as numbness to the lateral patellar area extending to the lower leg. The employee reported occasional color changes of the left knee with intermittent swelling. Physical examination revealed tenderness to palpation over the anterior and medial aspect of the knee. There was numbness present over the anterior lateral aspect of the knee. There was a well-healed incisional scar. There was normal color, temperature, and distal perfusion to the lower extremities. The employee was assessed with pain in the lower leg joint and knee joint replacement. The employee's medications were refilled.

The employee attended five sessions of individual/group therapy from 03/05/10 through 04/09/10.

The employee was seen for Designated Doctor Evaluation on 04/22/10. The employee complained of daily pain in the left knee, bilateral hands, bilateral elbows, right shoulder, and neck. The pain rated 6 out of 10. Physical examination revealed normal skin color, hair growth, sweat pattern, and temperature. There was tenderness to palpation of the wrists bilaterally. There was decreased muscle strength of the elbows, forearms, wrists, and hands. Deep tendon reflexes were 2+ and symmetric. Phalen's test was negative. Tinel's test was positive bilaterally. Sensation to pinprick and light touch was decreased in the thumb and index finger on the right. Examination of the left knee revealed no swelling or effusion. There was no medial or lateral joint line tenderness. There was normal tracking of the patella without crepitus. There were negative anterior and posterior drawer signs. McMurray's was negative. Range of motion of the left knee revealed extension to 0 degrees and flexion to 90 degrees. The employee was assessed with left knee tear of the medial meniscus, degenerative arthritis of the left knee, bilateral carpal tunnel syndrome, and complex pain syndrome of the left knee. The employee was thought to be able to return to work.

The employee was seen for evaluation on 07/30/10. The employee continued to have knee pain that worsened with prolonged standing and walking. Physical examination revealed a well-healed scar along the midline left knee. There was no allodynia, edema, or decreased range of motion of the left knee. There was slight tenderness to palpation diffusely and decreased sensation along the anterior aspect of the left knee joint. The employee was assessed with chronic pain syndrome, pain in lower leg joint, and pain with psychological factors. The employee's medications were refilled. The employee was recommended for additional individual therapy sessions.

The employee was seen for evaluation on 10/01/10. The employee reported 75%-100% reduction in her pain as a result of her medications. The employee continued to follow a home exercise program. Physical examination revealed extensive scarring to the anterior aspect of the left knee joint. There was no allodynia, edema, or decreased range of motion of the left knee. There was tenderness to palpation along the medial and lateral aspect of the left knee joint. There was no significant crepitus appreciated with knee extension and flexion. The employee was assessed with chronic pain syndrome, knee joint replacement, and pain in lower leg joint. The employee was continued on Voltaren, Lyrica, Prozac, and Hydrocodone.

The employee was seen for evaluation on 12/29/10. The employee had continued pain complaints rating 7 to 8 out of 10. Physical examination revealed the employee ambulates independently. There was gross normal strength and sensation to the bilateral lower extremities. There was a well-healed surgical incision to the left knee. The employee was assessed with pain in lower leg joint, knee joint replacement, and chronic pain syndrome. The employee was prescribed MS Contin 15mg, Hydrocodone

10/500, Prozac, and Lyrica.

The employee was seen for follow up on 01/10/11. The employee was unable to tolerate MS Contin secondary to sedation. Physical examination revealed no edema noted in the bilateral lower extremities. The employee ambulated independently. There was gross normal strength and sensation in the bilateral lower extremities. There was a well-healed incision to the left knee. The employee was assessed with pain in lower leg joint, knee joint replacement, and chronic pain syndrome. The employee was recommended for lumbar sympathetic block. The employee was changed from MS Contin to Lortab 10/500 mg.

The request for left lumbar block, fluoroscopy, and moderate sedation was denied by utilization review on 01/20/11 due to no documentation provided to support the medical necessity of lumbar sympathetic block. The employee complained of knee pain. Physical examination documented normal gait and no gross neurological deficits. Lumbar sympathetic block was not a treatment for the listed diagnoses.

The request for left lumbar block, fluoroscopy, and moderate sedation was denied by utilization review on 01/31/11 due to no evidence on clinical examination to support any discussion of sympathetic blocks. There was nothing to suggest the presence of the 8 AMA criteria for CRPS. Extremity pain was not a diagnosis for which sympathetic blocks are indicated. The entire plan of treatment was in question.

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

The request for left lumbar block is not recommended as medically necessary. The employee has complaints of knee pain; however, there are no objective findings noted in the physical examination consistent with RSD or CRPS that would require diagnostic blocks. Current evidence based guidelines recommend the use of lumbar sympathetic blocks to confirm a diagnosis of RSD or CRPS. There is no support in current evidence based guidelines for lumbar sympathetic blocks for non-specific chronic knee pain. As the request is not consistent with guideline recommendations, medical necessity is not supported.

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

*Official Disability Guidelines*, Online Version, Pain Chapter