



IMED, INC.

11625 Custer Road • Suite 110-343 • Frisco, Texas 75035
Office 972-381-9282 • Toll Free 1-877-333-7374 • Fax 972-250-4584
e-mail: imeddallas@msn.com

Notice of Independent Review Decision

DATE OF REVIEW: 06/17/11

IRO CASE NO.:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Item in dispute: LESI @ L4-5 (62311, 77003, 72275, 62264)

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

Texas Board Certified Orthopedic Surgeon

REVIEW OUTCOME

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

Denial Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

PATIENT CLINICAL HISTORY (SUMMARY):

The employee is a female who sustained an injury on xx/xx/xx when she tripped and fell, twisting her low back and right knee.

The employee saw Dr. on xx/xx/xx with complaints of low back pain and right knee pain. Physical examination revealed spasm to palpation of the bilateral thoracolumbar paraspinal musculature. Percussion elicited a pain response at T12-S1. Kemp's test was positive for increased low back pain. Lumbar range of motion revealed flexion to 38 degrees with pain, extension to 10 degrees with pain, and lateral flexion to 10-12 degrees with pain. There was limited range of motion of the right knee. The employee was assessed with lumbar herniated nucleus pulposus, lumbar radicular neuralgia, and internal derangement of the right knee. The employee was recommended for radiographs of the right knee and lumbar spine.

Radiographs of the right lumbar spine performed 04/22/10 demonstrated hypolordosis with restricted range of motion upon flexion. There was no segmental instability. There was no fracture or aggressive vertebral abnormality. There was mild to moderate disc space narrowing at L4-L5 with encroachment of the foramen. There was an accentuated lumbosacral angle.

Radiographs of the right knee performed 04/22/10 demonstrated no acute or aggressive radiographic abnormality.

The employee saw Dr. on 04/29/10 with complaints of pain in the low back and right leg. Current medications included Vicoprofen, Flexeril, and Naprosyn. Physical examination revealed decreased lumbar range of motion with pain. Seated straight leg raise produced low back pain. There was no sciatic notch or sacral iliac joint tenderness. The employee ambulated without the use of assistive devices. There was full motor strength throughout. The reflexes were 2 symmetrically. The employee was assessed with low back pain. The employee was prescribed Flexeril, Vicodin, and

Naproxen.

An MRI of the lumbar spine performed 05/07/10 demonstrated minimal dorsal annular bulge at L4-L5 without herniation. Disc hydration was adequate. There was no neural compression. There was mild encroachment of the spinal canal due to facet and ligamentum flavum hypertrophy. At L5-S1, disc height and hydration were adequate. There was dorsal annular bulge and fissuring measuring 2 mm. There was no neural compression and no stenosis. The paraspinal lumbar musculature showed mild atrophy of the erector spinae.

An MRI of the right knee performed 05/07/10 demonstrated Grade II active intrasubstance tear of the posterior horn of the medial meniscus. There was Grade II capsular sprain with edema and swelling of the posterior medial knee joint capsule. There was Grade II sprain of the anterior cruciate ligament. There was mild effusion of the knee.

The employee saw Dr. on 05/27/10 with complaints of pain in the low back and right leg. Physical examination revealed tenderness to palpation of the right calf. Straight leg raise was negative. There was full strength throughout. The employee was assessed with low back pain and right knee pain. The employee was referred for orthopedic evaluation of the right knee.

The employee saw Dr. on 08/03/10 with complaints of low back pain and right leg pain despite physical therapy. Current medications included Vicoprofen, Flexeril, and Naprosyn. Physical examination revealed the employee ambulated with a non-antalgic gait without the use of an assistive device. Cranial nerves II through XII were intact. There was no dysarthria, dysphonia, or aphasia. There was full motor power throughout. The employee was prescribed Ultram, Flexeril, and ibuprofen. The employee was assessed with low back pain and right knee pain. The employee was advised to follow-up in one month.

The employee saw Dr. on 10/13/10 with complaints of right leg pain. Physical examination revealed range of motion of the right knee from 0 to 140 degrees. There was no significant medial or joint line tenderness. McMurray's was negative. There was tenderness to palpation of the mid to distal IT band. The employee was assessed with right IT band tendinitis and internal derangement of the right knee. The employee was recommended for physical therapy and possible surgical intervention.

The employee saw Dr. on 10/26/10 with complaints of pain in the low back and right knee rating 5 to 7 out of 10. Physical examination revealed the patellar reflexes to be 2+ on the left and 1+ on the right. The Achilles reflexes were 2+ bilaterally. There was evidence of mild paresthesias in the right lateral leg. Motor strength was weakened in the right lower extremity, secondary to knee pain. Straight leg raise was reported to be positive on the right. There was tenderness to palpation of the medial aspect of the right knee. Range of motion of the right knee was from 0 to 115 degrees. The employee was assessed with possible medial meniscal tear of the right knee and L4-L5 disc bulge with right-sided radiculitis. The employee was recommended for surgical repair of the right knee and lumbar epidural steroid injection. The employee was prescribed Mobic, Tizanidine, and Vicodin.

The employee was seen for Designated Doctor Evaluation on 10/30/10. The employee complained of low back pain and right knee pain rating 8 out of 10. Physical examination revealed a minimally antalgic gait. Lumbar range of motion was within normal limits. There was full strength throughout. Sensation was intact. There was point tenderness over the low back and around the sacroiliac joint, posterior superior iliac spine, and gluteus medius. Lachman's and McMurray's were negative. Straight leg raise was negative. Range of motion of the right knee was from 0 to 135 degrees.

The employee was placed at Maximum Medical Improvement (MMI) and assigned a 5% whole person impairment.

The employee underwent arthroscopy with medial meniscectomy of the right knee with insertion of postoperative Marcaine infusion on 11/17/10.

The employee saw Dr. on 11/23/10 with complaints of pain in the low back and right knee rating 7 to 8 out of 10. Physical examination revealed tenderness to palpation over the medial and lateral joint line of the right knee. Range of motion was limited secondary to pain. Examination of the lumbar spine revealed tenderness to palpation. Lumbar range of motion was decreased with pain. Straight leg raise was reported to be positive on the right. Motor strength of the right lower extremities was weakened, secondary to recent surgery. The employee was recommended for lumbar epidural steroid injection.

The employee saw Dr. on 12/09/10 with complaints of pain in the lumbar spine and right knee rating 9 out of 10. Physical examination revealed tenderness and spasm to palpation of the lumbar spine. Lumbar range of motion was decreased. There was tenderness to palpation of the right upper thigh region. Range of motion of the right knee was from 0 to 120 degrees. There was no effusion. The knee was stable. Sensation was intact distally. The employee was assessed with medial meniscal tear of the right knee and disc bulge at L4-L5 and L5-S1. The employee was continued on her current medications. The employee was recommended for lumbar epidural steroid injection, but the note stated the employee was not felt to be a surgical candidate.

The employee was seen for psychotherapeutic evaluation on 01/03/11. The employee complained of pain in the low back pain and right knee rating 8 to 9 out of 10. Current medications included Meloxicam, Hydrocodone, Tizandine, and Zolpidem. Mental status examination revealed the employee to be depression, anxious, and very tearful. There was no evidence of formal thought disorder, delusions, or hallucinations. The employee's BAI score was 28 and her BDI score was 54. The employee's GAF score was 50. The employee was recommended for six to eight individual therapy sessions.

Electrodiagnostic studies performed 01/15/11 demonstrated prolonged F-wave on the right peroneal nerve, as well as increased insertional activity and few positive sharp waves were seen at the right mid lumbar paraspinal muscles and the muscles innervated by the right L4 nerve root. These findings support right L4 nerve root irritation. No frank active denervation was seen. There was no evidence suggestive of peripheral neuropathy, myopathy, or nerve entrapment of the bilateral lower extremities.

The employee saw Dr. on 01/25/11 with complaints of pain in the low back and right knee rating 7 out of 10. Physical examination revealed tenderness to palpation of the mid to lower lumbar region. Lumbar range of motion was decreased with flexion and extension. There was diminished sensation along the right L4-L5 distribution. Motor strength was weakened on the right, secondary to right knee pain. There was tenderness to palpation over the medial and lateral joint line of the right knee. Range of motion of the right knee was from 0 to 120 degrees with pain. There was no instability noted. The employee was assessed with medial meniscal tear of the right knee and L4-L5 disc bulge with L4-L5 radiculopathy. The employee was recommended for lumbar epidural steroid injection.

The employee saw Dr. on 01/26/11 with complaints of pain in the low back and right leg. Current medications include Mobic, Zanaflex, and Ambien. Physical examination revealed the cranial nerves II through XII to be grossly intact. The employee ambulated with a normal gait without the use of an assistive device. The

employee was assessed with low back pain and right knee pain. The employee was prescribed Effexor XR 37.5 mg.

A Functional Capacity Evaluation (FCE) was performed on 03/16/11. The employee was capable of performing at a sedentary physical demand level. The note stated the employee demonstrated inconsistent performance during testing.

The employee saw Dr. on 03/24/11 with complaints of low back pain and right knee pain rating 8 to 9 out of 10. Physical examination revealed tenderness to palpation of the lumbar spine. Straight leg raise was reported to be positive on the right. There was diminished sensation along the right L4 and L5 distribution. Motor strength was weakened on the right secondary to knee pain. There was tenderness to palpation over the medial and lateral joint line of the right knee. Range of motion was from 0 to 120 degrees with mild pain. There was no instability noted. The employee was assessed with medial meniscal tear of the right knee and L4-L5 disc bulge with right L4-L5 radiculopathy. The employee was recommended for lumbar epidural steroid injection.

An FCE was performed on 04/15/11. The employee's occupation as a required a medium physical demand level. The employee was currently able to perform at a light physical demand level.

The employee saw Dr. on 05/06/11. Physical examination revealed severe tenderness to the mid to lower lumbar region. Lumbar range of motion was decreased with extension. Straight leg raise was reported to be positive on the right. There was decreased sensation along the right L4 and L5 distribution. Motor strength was weakened in the hip flexors, hip abductors, and hip adductors on the right. There was tenderness to palpation over the medial and lateral joint line of the right knee. Range of motion of the right knee was from 0 to 120 degrees with pain. There was no instability noted. The employee was assessed with L4-L5 disc bulge with right L4-L5 radiculopathy and medial meniscal tear of the right knee. The employee was recommended for lumbar epidural steroid injection.

The request for epidural steroid injection was denied by utilization review on 05/16/11 due to lack of evidence of radiculopathy or denervation.

The employee saw Dr. on 05/17/11. Physical examination revealed severe tenderness of the mid to lower lumbar region. Lumbar range of motion was decreased with extension. Straight leg raise was reported to be positive on the right. There was diminished sensation along the right L4 and L5 distribution. There was weakness of the right hip flexors, hip abductors, and hip adductors. The employee was recommended for lumbar epidural steroid injection.

The request for epidural steroid injection was denied by utilization review on 05/26/11. There was evidence of L4-L5 nerve root irritation on electrodiagnostic studies; however, no denervation potentials were demonstrated.

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

The request for an LESI @ L4-5 would not be recommended as medically necessary. The clinical documentation provided for review provides insufficient objective evidence to support a diagnosis of lumbar radiculopathy. The MRI of the lumbar spine provided for review does not reveal any evidence of neurocompressive lesions that would be consistent with the employee's physical examinations or electrodiagnostic studies. The MRI study indicates that there was no disc herniation that contributes to foraminal or lateral recess stenosis that would irritate the nerve roots at L4-L5. As current evidence-

based guidelines recommend that there be unequivocal evidence of lumbar radiculopathy, which is not supported by the clinical documentation provided, the requested epidural steroid injections would not be indicated.

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

Official Disability Guidelines, Low Back Chapter

Criteria for the use of Epidural steroid injections:

Note: The purpose of ESI is to reduce pain and inflammation, thereby facilitating progress in more active treatment programs, reduction of medication use and avoiding surgery, but this treatment alone offers no significant long-term functional benefit.

- (1) Radiculopathy must be documented. Objective findings on examination need to be present. Radiculopathy must be corroborated by imaging studies and/or electrodiagnostic testing.
- (2) Initially unresponsive to conservative treatment (exercises, physical methods, NSAIDs and muscle relaxants).
- (3) Injections should be performed using fluoroscopy (live x-ray) and injection of contrast for guidance.
- (4) *Diagnostic Phase:* At the time of initial use of an ESI (formally referred to as the “diagnostic phase” as initial injections indicate whether success will be obtained with this treatment intervention), a maximum of one to two injections should be performed. A repeat block is not recommended if there is inadequate response to the first block (< 30% is a standard placebo response). A second block is also not indicated if the first block is accurately placed unless: (a) there is a question of the pain generator; (b) there was possibility of inaccurate placement; or (c) there is evidence of multilevel pathology. In these cases a different level or approach might be proposed. There should be an interval of at least one to two weeks between injections.
- (5) No more than two nerve root levels should be injected using transforaminal blocks.
- (6) No more than one interlaminar level should be injected at one session.
- (7) *Therapeutic phase:* If after the initial block/blocks are given (see “Diagnostic Phase” above) and found to produce pain relief of at least 50-70% pain relief for at least 6-8 weeks, additional blocks may be supported. This is generally referred to as the “therapeutic phase.” Indications for repeat blocks include acute exacerbation of pain, or new onset of radicular symptoms. The general consensus recommendation is for no more than 4 blocks per region per year. ([CMS, 2004](#)) ([Boswell, 2007](#))
- (8) Repeat injections should be based on continued objective documented pain relief, decreased need for pain medications, and functional response.
- (9) Current research does not support a routine use of a “series-of-three” injections in either the diagnostic or therapeutic phase. We recommend no more than 2 ESI injections for the initial phase and rarely more than 2 for therapeutic treatment.
- (10) It is currently not recommended to perform epidural blocks on the same day of treatment as facet blocks or sacroiliac blocks or lumbar sympathetic blocks or trigger point injections as this may lead to improper diagnosis or unnecessary treatment.
- (11) Cervical and lumbar epidural steroid injection should not be performed on the same day. (Doing both injections on the same day could result in an excessive dose of steroids, which can be dangerous, and not worth the risk for a treatment that has no long-term benefit.)