

- 3-21-12 DO., office visit.
- 3-28-12 MD., office visit.



CLAIMS EVAL

*Utilization Review and
Peer Review Services*

Notice of Independent Review Decision-WC

DATE OF REVIEW: 5-31-12

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Myelography, lumbosacral, radiological supervision, and interpretation

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

American Board of Orthopaedic Surgery-Board Certified

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.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

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PATIENT CLINICAL HISTORY [SUMMARY]:

PAC., the claimant works as a and was injured on xx/xx/xx. The claimant states she was standing near her desk when the leg of the desk fell and landed on her right leg and foot. She went home and applied ice and elevated leg. She worked in the office today. She has right knee pain 8-10, right foot pain 5-10. She denies any radiating pain or paresthesia. She states she is limping and not able to move her right toe. She has history of status post left knee ACL repair and bilateral foot surgery (lateral aspect due to enlargement). Assessment: Knee contusion, foot contusion. Plan: The claimant was prescribed Tylenol. The claimant is allergic to NSAIDs and states she doesn't recall why Ultram was discontinued in the past.) The claimant states she has left over Vicodin and she will take if she needs it.) Schedule for therapy daily for 3 days for injury care. Evaluate and treat, home exercise program as instructed.

Physical Therapy from 2-28-06 through 4-18-06 (9 visits).

Follow-up visit with Dr. on 3-7-06 notes the claimant was continued with medications and physical therapy.

4-24-06 MRI of the right knee performed by MD., showed previous ACL repair with intact repair graft, PCL, LCL, MCL, extension mechanism and a menisci likewise intact. Mild tricompartmental osteoarthritis most significant in the lateral, and medial compartments.

5-8-06 MD., the claimant complains of right knee pain. Impression: Pain, NOS (joint) (right) knee. Plan: Today the evaluator reviewed the claimant's MRI with her and informed her that she has some arthritic changes and iliotibial band friction syndrome. The evaluator is recommending she be treated conservatively with physical therapy. The evaluator informed her that the numbness and tingling should resolve. If her pain

has not improved within six weeks, we will consider a cortisone injection. She should avoid pounding exercises and also was instructed not to do any lifting, pushing or pulling over 20 pounds. The evaluator will see her back in six weeks for a follow up exam.

6-19-06 xxxxx, MD., the claimant arrives today for a six week follow up of the right knee. She has not attended any formal therapy due to it being denied and due to conflicting schedules. She states that she has not had any improvement since her previous visit. She has been working on some exercises on her own at home. Most of her discomfort she describes as tightness across the patella. She has some occasional locking of the knee with prolonged walking or standing. Impression: Pain, NOS (joint) (right) knee. Plan: The evaluator stressed the importance of her working on her exercises daily. She may return to work without restrictions. She was instructed to return in six weeks.

6-28-06 MD., the claimant returns today for an increase in right knee pain. She states that she continues to have pain, discomfort and swelling. She states that she has tightness throughout her knee. She states that she would like to discuss her work restrictions since she feels she needs some. She states that she has been doing her daily exercises. She states that stair climbing increases her pain and causes swelling. Impression: Pain, NOS (joint) (right) knee, osteoarthritis, knee (primary) localized (right) knee. Plan: The claimant has osteoarthritis in her knee primarily in the medial and lateral compartment. The evaluator recommended a cortisone injection to help relieve her pain. The evaluator explained that the injection is not a permanent fix. The evaluator explained that being on her feet all day and going up and down stairs can increase her swelling. She wished to proceed with the injection, and tolerated the procedure well. The evaluator recommended that she begin another course of physical therapy. Her work status is no kneeling, squatting, ladders, or stairs. No pushing, pulling, lifting or carrying anything over 25 pounds. She is to return in 6 weeks. Injection: Informed consent was given. Using aseptic technique, an injection was performed into the (right) knee. The medication utilized was 1 cc Depo, 1 cc Dexamethasone, and 6cc Marcaine. The claimant tolerated the procedure well.

7-29-06 MD., performed a Designated Doctor Evaluation. He certified the claimant had reached MMI on 7-29-06 and awarded the claimant 0% whole person impairment.

8-18-06 MD., the claimant returned for a follow up of the right knee. She states that the injection helped decrease most of her pain. She states that her pain is a 3-10. Her biggest complaint is numbness of the knee. She did not attend formal therapy, but states that she is working on a HEP. Impression: Pain, NOS (joint) (right) knee, osteoarthritis, knee (primary) localized (right) knee. Plan: The evaluator explained to the claimant that she does have some wear and tear in her right knee. The evaluator discussed the possibility of a knee replacement in the future. The evaluator feels that her accident may have caused some nerve damage that may or may not resolve. She may return to work full duty. The evaluator will see her PRN.

10-24-06 EMG-NCV performed by MD., showed this is a mildly abnormal study of the right lower extremity, demonstrating a possible right low lumbar nerve root irritation. The only abnormality on today's study was recurrent positive sharp waves in the right low lumbar paraspinal muscles, suggesting that a lumbar radiculopathy may be present, but since this was the only abnormality present, the study could not localize the level of the lesion. An imaging study of the lumbar spine is therefore indicated to further evaluate for the presence of a radiculopathy. There is no evidence of an entrapment neuropathy. There is no suggestion of a lumbosacral plexus disorder. There is no evidence of a large fiber peripheral neuropathy. Conduction studies were performed along the right peroneal, tibial, sural, and superficial peroneal nerves. F wave studies were performed along the right peroneal and tibial nerves. Latencies, amplitudes, and conduction velocities were normal.

4-21-08 Unknown Dr., the claimant returned for follow-up. The claimant complains of right knee pain.

5-13-08 DC., the claimant presented to this office with right knee pain that occurred as a result of a work-related injury on xx/xx. The claimant reports that while employed with xxxxx, she injured her right knee. She reports that she was in a classroom when a desk collapsed on her hitting her in the right knee and right foot. She reports that she felt pain immediately. The claimant reports pain and weakness in the right knee and leg. Her pain is constant and is getting worse. She rates the pain as a 5-10 on a pain scale of 0-10. The pain level goes up to an 8-10 on pain scale. She describes the pain as a sharp, stabbing pain. She has swelling in the right leg and knee joint. The right leg is very sensitive to the touch. The covers bother her leg at night. The pain is so severe it wakes her up at night. She is miserable wearing pants because it hurts the leg so much. Diagnosis: Right knee pain, lumbar radiculopathy, r-o lumbar disc pathology, antalgic gait. Plan: MRI right shoulder. X-rays right shoulder and right clavicle. Refer to Dr.. Ortho evaluation.

5-21-08 Bone scan performed by MD., showed findings are most consistent with degenerative joint disease involving bilateral knees.

5-23-08 EMG-NCV performed by MD., showed EMG findings most likely represent a pain inhibited response in the right vastus medialis and vastus lateralis muscles but could represent old right femoral neuropathy. NCS findings suggest a bilateral peroneal motor neuropathy as well as a right saphenous (a femoral nerve) and right lateral dorsal cutaneous sensory neuropathy. Absent peroneal F waves and tibial H reflex latencies suggest bilateral L5 and S1 radiculopathy.

6-9-08 Functional Capacity Evaluation with PDL noted.

6-9-08 DC., the claimant complains of continued pain in the right knee and low back. She has continued numbness in the right knee and leg. The right leg continues to be swollen. She states her pain is worse at the end of the day. When her knee pain is

present, she also has low back pain. She is working and her job requires her to stand and walk. At the end of the day, she must sit and rest due to the right knee pain, right leg swelling, and low back pain. Her pain wakes her up at night. She has severe pain and discomfort if the sheet touches her right leg. Diagnosis: Right knee pain, lumbar radiculopathy, r-o lumbar disc pathology, antalgic gait. Plan: MRI lumbar spine. Reviewed EMG results. Reviewed bone scan.

6-19-08 MD., DWC-73: The claimant was returned to work from 6-19-08 without restrictions.

6-23-08 MRI of the lumbar spine without contrast performed by MD., showed the spine is lordotic with the posterior body line intact. The conus terminates at the L1-2 disc level and appears normal. The central spinal canal appears grossly preserved and the cauda equina structures normal. The heights of the bodies appear maintained and the signal normal. The disc space L4-5 is diminished in signal with posterior bulging of the disc and linear bright signal within the bulge commensurate with acute or subacute injury. The prevertebral soft tissues appear normal. Focal soft tissue inflammation is present posterior to the spinous process of L3 with subtle patchy inflammatory signal extending cephalad to the T12 spinous process level. At L5-S1, there is posterior bowing of the disc normal for this level. The central spinal canal, IVFs, and lateral recesses are patent. The posterior joints exhibit mild to moderate arthrosis bilaterally. The multifidi muscles appear normal. The visualized upper portion of the sacroiliac joints appear normal as seen. At L4-5, there is broad based central disc protrusion projecting approximately 4 mm into the central spinal canal compressing the anterior epidural fat and flattening the anterior thecal sac. There is mild hypertrophy of the flava ligaments moderately narrowing the central spinal canal. The transversing L5 nerves are displaced posteriorly and appear to be compressed against the flava ligaments and facets bilaterally, slightly more on the right. The IVFs and lateral recesses appear patent. At L3-4, the posterior disc margin appears intact. The central spinal canal, IVFs, and lateral recesses appear patent. A small capsular cyst is present on the right projecting posterolaterally associated with moderate arthrosis of posterior joints bilaterally. At T12-L1, L1-2, and L2-3, the posterior disc margins appear intact. The central spinal canal, IVFs, and lateral recesses appear patent. The posterior joints appear normal. The kidneys appear normal as visualized. The remainder of the prevertebral soft tissues appear normal as seen.

6-27-08 DO., DWC-73: The claimant was taken off work from 6-27-08 through 7-11-08.

6-27-08 Unknown Dr., the claimant returned for follow-up. Assessment: Lumbar radiculopathy, right knee pain. Plan: The claimant was prescribed Vicodin. Follow-up with Dr.

7-2-08 Unknown Dr., the claimant complains of right knee pain and numbness. The evaluator recommended CT myelogram of the lumbar spine. MR arthrogram of the right knee.

7-29-08 Functional Capacity Evaluation with no PDL noted.

7-29-08 DC., the claimant has continued complaints of pain in the right knee and lower back. She rates her right knee pain as a 10-10 on a pain scale of 0-10. Her pain is worse at the end of the day. She stands on her feet during her regular day. She is also complaining of continued numbness in the right leg from the thigh to the ankle. She reports pain with walking. She reports low back pain. She has popping, clicking and grinding in the right knee joint. The right knee locks and feels as if it is going to give out. Her low back pain is a 10-10 on a pain scale. At the end of the day it is hard for her to find a comfortable position. Her pain is interfering with ADLs. She has trouble sleeping due to the pain. She has difficulty performing her job duties due to her pain. Physical Examination: The claimant ambulates with an antalgic gait. There is tenderness to palpation of the medial and lateral aspect of the right knee joint line. Swelling is noted in the right knee, right thigh, and right calf. Right quadriceps atrophy is noted as compared to the left. McMurray's test is positive on the right. Right knee range of motion is decreased in flexion and extension. The claimant has pain with range of motion. Joint crepitus is present in the right knee with flexion and extension. Strength is a 5-5 in the right lower extremity and a 5-5 in the left lower extremity. There is tenderness in the lumbar spine midline. Muscle spasms are present. SLR is positive. Lumbar range of motion is decreased and painful in flexion and extension.

Diagnosis: Right knee pain, lumbar radiculopathy, lumbar discopathy, antalgic gait. Plan: The claimant is scheduled for a BRC to discuss the compensable injuries. The claimant states she has had low back pain from the time of the injury. When the desk fell on her right leg, she was against a wall. She notes the most severe pain at the time of her injury was in the right leg. As she was going through therapy, she began to complain of low back pain that has gotten increasingly worse. She notes no other provider has addressed her low back in regards to this injury. In all probability, the low back pain is related to the injury occurring on xx/xx/xx. In his medical opinion, the numbness in the right leg is not resulting from a knee injury, but from a low back injury occurring when the desk fell on the claimant.

8-4-08 DO., DWC-73: The claimant was returned to work from 8-4-08 through 8-8-08 with restrictions.

8-4-08 Unknown Dr., the claimant complains of back, right knee pain. Assessment: Lumbar radiculopathy, right knee pain. Plan: The claimant was prescribed Lidoderm Patch, Vicodin.

8-25-08 DO., DWC-73: The claimant was returned to work from 8-25-08 through 9-10-09 with restrictions.

8-25-08 Unknown Dr., the claimant complains of back pain. Assessment: Lumbar radiculopathy, right knee pain. Plan: The claimant was prescribed Lidoderm Patch, Celebrex.

9-11-08 DO., DWC-73: The claimant was returned to work from 9-11-08 through 10-13-08 with restrictions.

10-3-08 DO., DWC-73: The claimant was returned to work from 10-3-08 through 11-7-09 with restrictions.

10-3-08 Unknown Dr., the claimant complains of right knee pain. Assessment: Lumbar radiculopathy, right knee pain. Plan: Continue pain management.

10-30-08 MRI of the lumbar spine without contrast performed by MD., showed moderately prominent L4-L5 herniation and posterior element hypertrophic change, resulting in fairly pronounced canal stenosis with L5 root impingement within their lateral recesses. Milder degenerative changes noted at other levels. Dr. notified.

10-30-08 Medical Center-Emergency Room, MD., the claimant complains of back pain. Onset was today and is still present. It is described as being severe and in the area of the lower lumbar spine and radiating to the right hip. The quality is noted to be sharp and aching. Impression: Chronic back pain: lumbar herniated disk. Plan: The claimant was prescribed Vicodin, Valium, Medrol Dosepak.

11-3-08 Unknown Dr., the claimant returned for follow-up. Assessment: Lumbar radiculopathy, right knee pain. Plan: Continue pain management.

11-4-08 DO., DWC-73: The claimant was taken off work from 11-4-08 through 11-10-08.

11-24-08 Unknown Dr., the claimant returned for follow-up. Assessment: Lumbar radiculopathy. Plan: The claimant was continued with Vicodin, Zanaflex.

11-30-08 DO., DWC-73: The claimant was taken off work from 11-30-08.

12-8-08 PAC., the claimant with a 2 year history of ongoing lower back pain and right lower extremity radiculopathy without resolve in spite of physical therapy and 1 ESI. The evaluator has in fact offered this claimant an additional ESI and she has refused stating that she "just wants it fixed". Therefore based on clinical findings, findings on MRI and failure of all nonoperative treatments thus far to relieve her of her complaints of ongoing intractable pain, which has been severely limiting in her activities of daily living, and her employment, we have recommended a mini open T lift from the right at L4-L5 with pedicle screws. The claimant has agreed to undergo this procedure. The claimant understands the risks of this procedure to include the risk of CSF leak with headache, continued pain, weakness, numbness, paralysis, neurologic deficit, hemorrhage, stroke, not formulating a definitive diagnosis, the possible need for reoperation in the future, infection or death.

1-5-09 DO., DWC-73: The claimant was taken off work from 1-5-09 through 2-16-09.

1-5-09 Unknown Dr., the claimant returned for follow-up. Assessment: Lumbar radiculopathy. Plan: The claimant was continued with Vicodin, Zanaflex.

1-14-09 X-ray of the lumbar spine performed by MD., showed AP and lateral intra-operative views demonstrate bilateral pedicular screws bridging the L5-S1 level. There has been diskectomy with disk prosthesis. There is good alignment.

1-14-09 MD., preoperative and postoperative diagnosis: L4-5 disk degeneration, disk bulge, intractable back pain and right lower extremity pain. Procedure: Minimally invasive transforaminal lumbar interbody fusion, L4-5. Bilateral percutaneous pedicle instrumentation, L4-5. Right posterolateral fusion, L4-5. Decompressive right laminotomy and foraminotomy L4-5. Microscope use with microsurgical technique. Fluoroscopy use. Synthetic allograft bone placement. Synthetic interbody device placement.

1-17-09 PAC., the claimant has a two year history of lower back pain secondary to a desk falling onto her legs while working as a xx. She reported her symptoms as right-sided lower back pain with midline low back pain and pain radiating throughout her lumbosacral region. The claimant was also experiencing symptoms of right lower extremity radiculopathy. Based on clinical findings, findings on MRI and failure of physical therapy as well as ESIs to control this claimant's complaints of pain, the evaluator deemed this claimant a viable candidate for surgical intervention. Hospital course: The claimant was admitted on 1-14-09 and underwent the above named procedure. The claimant tolerated the procedure well. The claimant did experience moderate amount of postoperative pain and was managed with PCA as well as p.o. narcotic analgesics. The claimant was also evaluated and treated by physical therapy and occupational therapy to assist in her rehab. The claimant felt stable enough three days status post to be discharged home. The claimant was discharged on 1-17-09 and instructed to follow up in clinic in two weeks, not to work for two weeks, not to drive for two weeks, not to lift anything greater than 10 pounds for six weeks. The claimant was also given instructions on wound care and maintenance. The claimant verbalized understanding of all discharge instructions.

2-4-09 Physical Therapy Evaluation.

2-6-09 MD., the claimant is three weeks status post mini TLIF at L4-5. She states that she is "a lot better than before." She does report some lingering low back pain as well as persistent right foot numbness; however, she is sleeping better with decreased amounts of pain overall. Currently, she is working with home health physical therapy three times a week and doing her home exercise plan twice a day. She is using her wheelchair at the recommendation of the home health worker when she has "a lot of things to do." Otherwise, she uses a walker or nothing at all to ambulate. She reports ambulating with some difficulty secondary to right lower extremity subjective weakness; however, she states even this is improving with time. Physical Examination: Incisions are clean, dry, and intact x2. Impression: The claimant is three weeks status post mini TUE and progressing very well from a surgical standpoint. Clinically, this claimant is

experiencing significant reduction in the severity and frequency of her complaints of preoperative pain. Plan: The evaluator would like to follow-up with her in four weeks to continue to monitor her progress. The evaluator would like to request AP and lateral views of her lumbar spine on x-ray at follow-up. The claimant understands and agrees with this plan.

3-10-09 X-ray of the lumbar spine performed by MD., showed previous anterior-posterior lumbar fusion L4-5. Comparison of the current study to previous post fusion radiographs is recommended to assess the integrity of the right posterior interconnecting fusion rod and its connection to the right superior la pedicle screw.

3-12-09 MD., the evaluator performed a minimally invasive TLIF at L4-5 approximately nine weeks ago. She is here today reiterating that "my back feels a lot better." She walks with a walker but is now going to transfer to a four-point cane. She still is engaged in physical therapy and feels steady improvement. She has some numbness in her right anterior shin but otherwise feels that she is doing quite well with minimal back pain. She is decreasing her pain medication usage and only takes one pill in the morning and at lunch and two in the evening, which is a substantial improvement. She is doing home-based physical therapy exercises for now. Physical Examination: She has full strength and sensation throughout. X-ray: Screws are in good position at L4-5 bilaterally with intact interbody space and normal progression of the fusion. There appears to be a disconnect in the superior screw on the right at IA from the rod; however, there is nothing that would suggest instability on these x-rays. Impression: The claimant continues to make very nice clinical improvement following her minimally invasive fusion. At this time, the evaluator does not feel there is any need to consider reoperation for the disconnection of the rods since she is doing very well clinically and is having good progression of her fusion. This should be inconsequential.

Plan: The evaluator has enrolled her in formal physical therapy to see if that would provide some additional benefit. The evaluator will see her back in my clinic in six weeks. The evaluator has refined her prescriptions for Norco and Valium at this time.

Physical Therapy from 3-26-09 through 5-19-09 (3 visits).

4-15-09 X-ray of the lumbar spine performed by MD., showed status post hemilaminectomy and fusion L4-5. As previously noted, the connecting rod between the right L4 and L5 pedicle screws appears disconnected superiorly. This appearance is unchanged. No other adverse interval changes are noted when compared to the prior study of 3-10-09.

4-23-09 MD., the claimant is three months status post TLIF at L4-5. She has been doing very well. She has been participating in both land and water physical therapy. She feels some improvement and adds she is "getting around better." Her pain level is fluctuating and is worse in the morning; however, she has been able to decrease her medication slightly. She has decreased her cane use with walking. She still has some numbness in the right lower extremity but thinks her overall sensation is better. She adds that some days when she has pain she still is able to do her regular activities. Overall, she is doing

much better after surgery. Physical Examination: She has full motor and sensory function throughout. X-ray: Shows stable screw and rod position at L4-5 with the exception of disconnect that is unchanged at the right of L4-5. There is good interbody fusion progression. Impression: The claimant continues to make very nice surgical and clinical improvements. Plan: She is aware of the disconnect and knows that surgery is not necessary for repair at this time. She will return to the clinic in 12 weeks. She is off work for 12 more weeks, and she has a very physical job. The claimant understands and agrees with this plan. Dr. has seen and evaluated this claimant today.

Follow-up visit with Unknown Dr. on 6-22-09 notes the claimant was continued with medications (Vicodin, Celebrex).

6-29-09 X-ray of the right knee performed by DC., showed arthrosis of the tibiofemoral joint with what the evaluator suspect is an osteochondral defect in medial femoral articular condyle. Arthrosis of the patellofemoral articulation with what appears to be a focal area of erosion in the superior trochlea. Previous ACL repair.

6-30-09 PAC., the claimant who is 5.5 months status post mini-TLIF at L4-5. She states she is still experiencing some right-sided buttock and low back pain that she describes as "catches and locks." The leg symptoms have improved overall. She has been participating in physical therapy for the last six weeks approximately 2-3 times a week. She states that physical therapy has helped, and she is currently doing a home exercise plan, including walking and climbing stairs. She is using a cane to stand up from a sitting position or get up out of bed. She has lost 15 pounds since her last visit. Overall, she feels she is getting better, but her lower back pain is still there. Physical Examination: She has 4-5 motor function bilaterally throughout secondary to effort. She does have some hypersensitivity to the right lateral calf and decreased sensitivity to the right lateral thigh. X-ray: Shows intact screws with right disconnect at L4-5 stable. Good interbody progression noted. Impression: The claimant is 5.5 months status post mini-TLIF at L4-5. She has had improvement overall with low back pain and right lower extremity symptoms. However, she is still experiencing some slight low back pain and right buttock pain. Plan: The evaluator would ask that she continue her physical therapy and exercises and return to the clinic in six months for further follow-up. The evaluator would consider her to be a possible spinal cord stimulator candidate in the future if she has no improvement. The claimant understands and agrees with this plan. Dr. has seen and evaluated this claimant today.

Follow-up visit with Unknown Dr. on 6-22-09, 7-20-09, 7-23-09, and 8-3-09 notes the claimant was continued with medications (Vicodin, Celebrex). Continue low back strengthening. Needs arthroscopy. Consider Work Hardening. Consult Dr..

8-14-09 Unknown Dr., the claimant returned for follow-up. The claimant complains of locking, sharp pain shooting down ankle, right side. Assessment-Plan: Diagnostic arthroscopy. (Other illegible hand written notes).

8-31-09 Unknown Dr., the claimant returned for follow-up. Assessment-Plan: Internal derangement, right knee surgery pending, status post lumbar surgery L4-5. Plan: Awaiting knee surgery. (Other illegible hand written notes).

9-28-09 Unknown Dr., the claimant returned for follow-up. Medications were denied. Assessment-Plan: Internal derangement, right knee surgery pending. Plan: The claimant was prescribed Norco. (Other illegible hand written notes).

9-28-09 DO., DWC-73: The claimant was taken off work from 9-28-09.

10-5-09 Unknown Dr., the claimant returned for follow-up. Bandage change. Assessment-Plan: Internal derangement, right knee surgery pending. Plan: The claimant was prescribed Norco. (Other illegible hand written notes).

10-5-09 DO., DWC-73: The claimant was taken off work from 10-5-09 through 10-22-09.

10-19-09 Unknown Dr., the claimant returned for follow-up. Assessment-Plan: Status post knee surgery, right knee pain. Plan: Continue disability. (Other illegible hand written notes).

10-19-09 DO., DWC-73: The claimant was taken off work from 10-19-09 through 11-23-09.

10-22-09 MD., the claimant presents postoperatively after an arthroscopy with mini arthrotomy, right knee medial meniscectomy and chondroplasty, and a joint resurfacing of the medial femoral condyle and the patella. She underwent surgery on 10-2-09. She states that she feels great. She is still on crutches and still wears a knee unloader brace. She has had a dressing change on Monday. Assessment: Status post right knee joint surgery, no complications. Plan: She is to start passive physical therapy with some friction massage. She is to continue using her crutches and her splint until she feels confident about load bearing. She is to continue Celebrex 200 mg one p.o. b.i.d. and Myoflam cream for pain and inflammation. She will return in three weeks.

11-23-09 Unknown Dr., the claimant returned for follow-up. The claimant returned for medication refill. Assessment-Plan: Status post knee surgery. Plan: Continue pain management. Begin physical therapy. Refill Norco. (Other illegible hand written notes).

12-21-09 Unknown Dr., the claimant returned for follow-up. Assessment-Plan: Status post knee surgery, right knee pain, DJD. Plan: Continue rehab. (Other illegible hand written notes).

1-4-10 DO., DWC-73: The claimant was taken off work from 1-4-10 through 2-8-10.

1-14-10 MD., the claimant continues to complain of pain in the knee along with minimal swelling. She scores the intensity of the pain in her knee at 5-10 on the VAS scale at its lowest. She states that it does go up to between 7 and 9-10 on VAS scale when she

walks. She describes the sensation as a tight rubber band around her knee. She also states that her knee catches while bending it. Assessment: Status post surgical repair of the right knee. Plan: She will continue physical therapy and medications that she obtains from her treating physician. Given the fact that she still has persistent swelling and has had joint resurfacing performed, the evaluator would like to evaluate her knee postoperatively with a CT scan of the knee with contrast. She will return in four weeks.

2-8-10 Unknown Dr., the claimant presents for medications refill. The claimant complains of knee still swollen. Assessment-Plan: Status post knee surgery, internal derangement pain. Plan: Continue Norco. Pending CT scan.

2-11-10 CT of the right knee without contrast performed by DC., showed advanced arthrosis of the tibiofemoral joint both medially and laterally with bone debris in the mid internal region of the lateral tibiofemoral joint space with osteochondral defect in the lateral femoral articular condyle probably representing the host site. Bone debris is present in the space between the intercondylar eminences. Some degree of chondromalacia patellae with subarticular patchy lucency of the medial articular trochlea that the evaluator suspect is due to focal contusion injury that has healed. The evaluator noted no evidence of infection. ACL repair with anchor screws and fixation screws appearing stable. The ACL graft is not visualized on this study.

2-12-10 Functional Capacity Evaluation shows the claimant is functioning at a Light PDL.

2-25-10 MD., the claimant continued management of pain in her knee.

There is no change in her condition since her last visit on 2-11-10. She complains of pain in the knee that she scores between 5 and 6-10 on the VAS scale today. Assessment: Status post surgical repair of the right knee. Plan: Arthroscopy and related procedures. After reviewing her MRI films, the prosthesis is not flush with the articular surface of the bone. This is causing the pain and joint effusion and resultant swelling. More importantly, the catch that she feels on bending the knee at approximately 30° is very likely because of this protruding prosthesis catching on cartilage and bone. After performing an arthroscopic evaluation of the joint, the evaluator might have to reseat the prosthesis. Of this, the evaluator is sure she cannot be left in the condition that she is in now. Her FCE very clearly states that she is functioning in a light category. Based on a written job description for her current position as a teacher's assistant for special education at AISD, she needs to have no restrictions and be able to function in a full capacity. Therefore, the arthroscopic evaluation of her knee with a possible reseat will allow her to return to functioning at a full capacity and thereby return to work. The evaluator will submit my proposals for preauthorization.

3-8-10 DO., DWC-73: The claimant was taken off work from 3-8-10 through 5-3-10.

Follow-up visit with Unknown Dr., on 3-8-10 notes the claimant continued with medications. (Other illegible hand written notes). Current medications: Celebrex and Norco.

3-26-10 MD., preoperative diagnosis: Internal derangement syndrome of the right knee joint, degenerative changes, status post prosthetic replacement of intercondylar notch of femur and possible patella surface and postoperative diagnosis: Right knee joint degenerative changes with loading of the medial compartment and severe patellar chondromalacia change with patellofemoral maltracking, hypertrophic plicae and synovitis, treated by means of arthroscopy with: Synovectomy. Resection of medial plicae. Patella chondroplasty, chondromalacia change, mechanical thermal. chondroplasty, mechanical thermal, of medial femoral condyle. Thermal chondroplasty, medial tibial plateau. Thermal chondroplasty, lateral femoral condyle. Lateral retinacular release, resetting all tissue from the inner to outer aspect of the knee joint on the lateral aspect of the patella, extending 2 to 2.5 cm above the superior pole of the patella and ending at the level of the lateral aspect of the tibial tubercle. Injection of 80 mg Kenalog, 8 cc of 0.5% Marcaine into right knee joint. Procedure: Arthroscopy of the right knee joint with the following procedures: Synovectomy, shaving hypertrophic synovitis throughout the region of the knee joint. Shaving resection of hypertrophic plicae in the medial compartment of the knee joint, parapatellar region, infrapatellar region freeing impingement on the medial condyle during flexion-extension of knee joint. Mechanical thermal chondroplasty, grade 4 chondromalacia change of the surface of the patella. Mechanical thermal chondroplasty, chondromalacia change of the medial femoral condyle. Thermal chondroplasty, medial tibial plateau. Thermal chondroplasty, lateral femoral condyle. Lateral retinacular release, freeing the lateral retinaculum and allowing normal patellofemoral tracking during flexion-extension of knee joint. Injection of 80 mg Kenalog, 8 cc of 0.5% Marcaine into the right knee joint.

Follow-up visit with Unknown Dr., on 3-30-10, 4-5-10, 5-3-10 notes the claimant continued with medications. (Other illegible hand written notes). Current medications: Celebrex and Norco.

5-6-10 MD., the claimant returned following surgical repair of her right knee. She states that she feels good. She has no pain while walking at present. She only has some discomfort when she is in physical therapy. She started physical therapy last Tuesday. She states that she is very happy with her surgery. There is no swelling on walking. There is no locking and no giving out. Assessment: Status post surgical repair of the right knee no complications. Plan: She will finish physical therapy. She will continue with anti-inflammatory medications.

6-3-10 MD., the claimant returned following surgical repair of her right knee. Examination of the right knee revealed the alignment and contour were normal. The surgical scars have healed well. There was minimal swelling over the suprapatellar region. There was hypersensitivity of the skin over the lateral patellar border and tenderness on palpating the anterior one-third of the lateral joint line. Patella tracking was good. Flexion of her knee was greater than 90 degrees. Extension was full. A 10 degrees valgus deformity of the knee was present as measured with the goniometer. Further manipulation of the knee was not performed. Assessment: Status post surgical

repair of the right knee no complications. Plan: She will finish physical therapy. She will continue with anti-inflammatory medications. She will follow up in four weeks.

6-7-10 DO., DWC-73: The claimant was taken off work from 6-7-10 through 8-1-10.

Follow-up visit with Unknown Dr., on 6-7-10, 7-12-10 notes the claimant continued with medications. (Other illegible hand written notes). Current medications: Celebrex and Norco.

7-12-10, DO., DWC-73: The claimant was taken off work from 7-12-10 through 8-9-10.

8-5-10 MD., the claimant complains of a grade 4-10 pain and swelling in her knee. Other maladies are that she has to squat in a hunch position by students as she teaches for 45 minutes at a time, but she is unable to do this. Diagnosis: Lumbar spine pain, lumbar spine pain, right knee pain. Plan: The evaluator would like to do a Synvisc injection times two of her right knee, give her anti-inflammatory topical ointment and return her to duties as soon as practicable.

Follow-up visit with Unknown Dr., on 8-9-10 notes the claimant continued with medications. (Other illegible hand written notes). Current medications: Celebrex and Norco.

8-9-10 DO., DWC-73: The claimant was taken off work from 8-9-10 through 9-13-10.

8-13-10 DO., performed a Designated Doctor Evaluation. He certified the claimant had reached MMI on 2-21-08 and awarded the claimant 14% whole person impairment.

9-2-10 MD., the claimant complains of right knee pain. Plan: Synvisc injections were administered today to the right knee. Follow up in 2 weeks.

9-9-10 EMG-NCV performed by DO., showed bilateral lower extremities nerve conduction and electromyography study is abnormal demonstrating lumbosacral radiculopathy at the L5, S1 nerve root level more pronounced on the right. There is no electro diagnostic evidence to suggest entrapment neuropathy or myopathy.

9-13-10 DO., DWC-73: The claimant was returned to work from 9-13-10 through 10-18-10 with restrictions.

Follow-up visit with Unknown Dr., on 9-13-10 notes the claimant complains of right knee and lumbar pain. The claimant continued with medications. (Other illegible hand written notes). Current medications: Celebrex and Norco.

9-30-10 MD., the claimant complains of chronic right knee pain. Procedure: The skin over the area was prepped x3 with surgical alcohol. Using sterile technique with a 23 gauge needle, the evaluator injected Marcaine and Celestone into the suprapatellar pouch area of her right knee. Applying an 18 gauge needle to the preloaded Synvisc

syringe, the evaluator entered the suprapatellar pouch area. The evaluator injected the Synvisc without difficulty into the suprapatellar pouch area of her right knee. Plan: Synvisc injection x 2 of her right knee done today. The evaluator is giving her anti-inflammatory topical ointment. Follow up in 4 weeks.

10-14-10 MD., the claimant had anterior surgery by the evaluator on 10-2-09; and again by Dr. 3-26-10. She had a meniscectomy chondroplasty for tricompartmental arthritis and has gotten back a good range of motion. She has full extension and full flexion, but still has some tightness in the knee from the scar tissue on the right medial and right lateral side. She has some mild crepitus in the patella, but not nearly as bad as it was. She has had a course of two injections of Synvisc. The evaluator would like to complete a third injection of Synvisc. The evaluator would also like for her to consider, as Dr. has recommended, a right total knee joint replacement. She is back teaching school where she has to squat or sit inside the children's desk. The stools are quite low. The evaluator asked Dr. to write her a prescription that she may take in a higher stool for herself, so her knee is not in quite such a flexed and power weighted position. Job modification might help her continue for quite a longer time. The final result of the knee surgery is full extension and 110 ° of flexion which is a good result of both open and arthroscopic surgery; especially for tricompartmental arthritis. Plan: The evaluator will initiate another bout of Synvisc injection because she cannot take off from school, and the evaluator is only in the 2nd or 3rd month of school (August, September, October). She would like to make it to June 3. Anytime after that, she would consider the right total knee replacement, if she continues to worsen and does not get better, although the evaluator suspects she will get better with time. The evaluator will recheck her again monthly as required by Workman's Compensation and allow her to continue to substitute teaching school. She has only missed a couple of days due to pain or illness with the knee thus far.

10-18-10 DO., DWC-73: The claimant was returned to work from 10-18-10 through 11-22-10 with restrictions.

Follow-up visit with Unknown Dr., on 10-19-10 notes the claimant complains of right knee and lumbar pain. The claimant continued with medications. (Other illegible hand written notes). Current medications: Celebrex and Norco.

10-19-10, DO., DWC-73: The claimant was returned to work from 10-19-10 through 11-22-10 with restrictions.

11-1-10 xxxxx, DC., this letter is in response to the Designated Doctor Exam the claimant underwent on 8-13-10 by DO. After reviewing the results of this exam, the evaluator agrees with the Designated Doctors findings of 14% whole person impairment. This impairment includes the right knee and low back injuries for the date of injury 2-23-06. The right knee was given 4% whole person impairment and the low back was given 10% whole person impairment. This claim for the injury date of 2-23-06 includes the injuries to the right knee and the injuries to the low back.

The claimant underwent surgery on the right knee on 3-26-10 with MD. Procedure performed: Synovectomy, shaving hypertrophic synovitis throughout the region of the right knee joint. Shaving resection of hypertrophic plicae in the medial compartment of the right knee joint, parapatellar region, infrapatellar region freeing impingement on the medial condyle during flexion-extension of the knee joint. Mechanical thermal chondroplasty, grade 4 chondromalacia change of the surface of the patella. Mechanical thermal chondroplasty, chondromalacia change of the medial femoral condyle. Thermal chondroplasty, medial tibial plateau. Thermal chondroplasty, lateral femoral condyle. Injection of 80 mg Kenalog, 8 cc of 0.5% Marcaine into the right knee joint. The claimant also underwent surgery on the lumbar spine with, MD on 1-14-09. Procedure performed: Minimally invasive transforaminal lumbar interbody fusion, L4-5. Bilateral percutaneous pedicle instrumentation, L4-5. Right posterolateral fusion L4-5. Decompressive right laminotomy and foraminotomy L4-5. Microscope use with microsurgical technique. Fluoroscopy use. Synthetic allograft bone placement. Synthetic interbody device placement. Given the above data on the listed procedures, the evaluator is not clear as to why the claimant insurance company is disputing the designated doctor's findings of a 14% whole person impairment rating when clearly the rating includes the right knee and the lumbar spine, both of which are accepted as compensable under this claim. It is clear to me however, that the claimant insurance company is trying to accept the findings of a designated doctor's report from 2006 that gives her 0% impairment in order not to pay her due impairment benefits. Obviously, the claimant has documented injuries from the 2-23-06 work-related accident. The designated doctor, in 2006, must not have had a complete set off medical records at the time of the examination.

11-18-10 MRI of the right knee without contrast performed by MD., showed complex tear of the anterior horn of the medial meniscus and the medial meniscus is subluxed medially. Fraying of the free edge of the anterior horn and body of the lateral meniscus. Intact anterior cruciate ligament graft. Moderate osteoarthritis. Chondromalacia patella and chondromalacia at the medial tibiofemoral joint. Small knee joint effusion.

Follow-up visit with Unknown Dr., on 11-22-10 notes the claimant complains of right knee and lumbar pain. The claimant continued with medications. (Other illegible handwritten notes). Current medications: Celebrex and Norco.

11-24-10 MD., the claimant had an on the job knee injury to the right knee after coming out of a building onto a flexed right knee. She has had a past medical history of knee surgery on her right knee on 3-26-01 and 10-2-09. Physical Examination: There is grinding on flexion and extension of the right knee. There is pain over the medial joint line and under the patella. Mild joint fluid accumulation. Assessment: She has continuing symptoms from tricompartmental arthritis and a torn anterior horn of the medial meniscus with subluxing medial meniscus. Plan: Schedule for third Synvisc injection into the right knee joint. She is unwilling to consider surgery until the school year is out as she wants to finish her teaching job and then consider any future surgical options.

Follow-up visit with Unknown Dr., on 12-20-10 notes the claimant complains of right knee and lumbar pain. The claimant continued with medications. (Other illegible hand written notes). Current medications: Celebrex and Norco.

12-23-10 MD., the claimant still has pain on flexion and extension of the knee and some mild to moderate grinding under the patella for chondral fractures. She has pain over the medial joint line and the lateral joint line. Her arthroscopy was such that we think she is going to be a total knee candidate. She had a fire drill at school recently and twisted her knee on the way out and felt excruciating pain in the knee. The pain today is about a 2-10. She is considering a right total knee joint replacement between now and June. She has requested one more Synvisc injection to tide her over until she decides if this is the route that she wants to go.

1-3-11 DO., DWC-73: The claimant was returned to work from 1-3-11 with restrictions.

Follow-up visit with Unknown Dr., on 1-3-11, 1-17-11, 2-21-11 notes the claimant complains of right knee and lumbar pain. The claimant continued with medications. (Other illegible hand written notes). Current medications: Celebrex and Norco.

2-21-11 DO., DWC-73: The claimant was returned to work from 2-21-11 through 3-21-11 with restrictions.

3-17-11 MD., the claimant complains of pain on a scale of 1-10 is an 8-10 in the right knee. She states her right knee is still catching, popping, locking, grinding and giving way. Aggravating factors are standing, walking, bending, squatting and sudden movements, carrying of anything and all physical activities on the right knee. Alleviating factors are stopping activity, topical analgesics, medication and resting. Claimant states she does not like taking her medication; however her body is at the point she has to take it because of the pain in the knee. Diagnosis: Chronic pain, internal derangement right knee, pain in knee joint. Plan: Right total knee replacement at her earliest possible opportunity. The evaluator is not prescribing any DME at this time. She refuses further Synvisc injections. She only has to make it through April and May before she is eligible for her total knee replacement.

3-21-11 DO., DWC-73: The claimant was returned to work from 3-21-11 with restrictions.

Follow-up visit with Unknown Dr., on 3-21-11, 4-21-11, 5-20-11 notes the claimant complains of right knee and lumbar pain. The claimant continued with medications. (Other illegible hand written notes). Current medications: Celebrex and Norco.

5-20-11 DO., DWC-73: The claimant was returned to work from 5-21-11 with restrictions.

6-1-11 MD., the claimant complains of right knee pain. Diagnosis: Degenerative joint disease status post patella button. Plan: She most definitely, based upon today's evaluation is a candidate for a total knee arthroplasty.

Follow-up visit with Unknown Dr., on 6-20-11 notes the claimant complains of right knee and lumbar pain. The claimant continued with medications. (Other illegible hand written notes). Current medications: Celebrex and Norco.

6-20-11 X-ray of the chest performed by xxxxxxxxxxxx, MD., showed no acute cardiopulmonary disease. Degenerative changes of the acromion on the right.

6-20-11 DO., DWC-73: The claimant was returned to work from 6-20-11 through 7-18-11 with restrictions.

Follow-up visit with Unknown Dr., on 6-27-11 notes the claimant complains of right knee and lumbar pain. The claimant continued with medications. (Other illegible hand written notes). Current medications: Celebrex and Norco.

6-27-11 DO., DWC-73: The claimant was taken off work from 6-27-11 through 7-18-11.

7-12-11 MD., the claimant who is post right total knee replacement. The evaluator had recommended that she start her physical therapy but it has not yet occurred. She has no complaints. Diagnosis: Status post total knee replacement of the right knee. Plan: Notwithstanding the fact that the evaluator gave her an order for therapy, this has not begun, and as a result obviously she now has a flexion contracture. The evaluator is removing her staples. The evaluator is giving her another prescription for physical therapy. The evaluator has impressed upon her how important this is and that if she does not regain extension over the next 6 weeks, the evaluator will have to schedule her for an MUA.

7-18-11 DO., DWC-73: The claimant was taken off work from 7-18-11 through 8-1-11.

Follow-up visit with Unknown Dr., on 7-18-11, 8-1-11 notes the claimant complains of right knee and lumbar pain. The claimant continued with medications. (Other illegible hand written notes). Current medications: Celebrex and Norco.

8-1-11 DO., DWC-73: The claimant was taken off work from 8-1-11 through 8-12-11.

8-13-11 MD., the claimant is here for follow up and a second opinion in regards to right total knee arthroplasty. She had a right total knee arthroplasty performed by Dr. on 6-22-11. She has been going through physical therapy and has just finished her first round of physical therapy. She has numerous complaints including the inability to fully extend her knee, some to flexion, still has popping in her knee, and she states she is unable to dorsiflex her great toe and other toes although she has good dorsiflexion of the ankle. She has not had any other recurrent injuries and no specific numbness. She saw Dr. yesterday who apparently by her history recommended ongoing physical

therapy, a turnbuckle brace, consideration of manipulation under anesthesia, and a lumbar MRI. So she is here for further evaluation and a second opinion. Assessment: Status post right total knee arthroplasty approximately six weeks ago with some limited range of motion. Plan: The evaluator discussed with her. The evaluator agree with all of Dr. plans including continuing with the turnbuckle brace, with him proceeding with manipulation under anesthesia, and working on intensive physical therapy. The evaluator discussed with her the toe range of motion is probably due to some mild nerve stretching and shoulder resolve with time, although evaluator agrees with an MRI of her back as well. The evaluator encouraged her that she is a little bit behind in her therapy but should be able to catch up with intensive therapy and with Dr. interventions. Since she does not need any other surgery or surgical revision at this point in time, the evaluator will turn her over to Dr. and then Dr. for ongoing management.

Follow-up visit with Unknown Dr., on 8-15-11 notes the claimant complains of right knee and lumbar pain. The claimant continued with medications. (Other illegible hand written notes). Current medications: Celebrex and Norco.

8-15-11 DO., DWC-73: The claimant was returned to work from 8-17-11 through 8-29-11 with restrictions.

8-25-11 MRI of the lumbar spine with and without contrast performed by Dr. , showed previous L4-5 fusion. Although there is some metallic artifact at the right L4-5 foramen, soft tissue fills this right foramen, concerning for a large recurrent disc herniation. This could irritate right L5 as it descends and-or right L4 in the foramen. A CT lumbar myelogram could be obtained to confirm the suspected findings of a large right foraminal disc herniation at L4-5.

8-29-11 DO., DWC-73: The claimant was returned to work from 8-29-11 through 9-12-11 with restrictions.

Follow-up visit with Unknown Dr., on 8-29-11, 9-12-11, 10-10-11, 11-14-11 notes the claimant complains of right knee and lumbar pain. The claimant is to continue medications. (Other illegible hand written notes).

11-14-11 DO., DWC-73: The claimant was taken off work from 11-14-11 through 12-14-11.

11-17-11 MD., the claimant complains of right knee pain. The claimant has had her manipulation under anesthesia. She has easily obtained recurvatum of 5 degrees and farther flexion to 120 degrees. The evaluator had ordered a turn-buckle splint and had no obstructions to obtaining it. Now the evaluator has a denial stating a turn-buckle use is not for contractures and for stabilization. Who would have thought that anyone would order a turn-buckle brace for anything but contractures. This reviewer for some reason thinks that we would want stabilization when the patient has a stiff knee. It is so illogical and it is extremely frustrating because now, once again, this claimant's knee is stiff. Diagnosis: Loss of range of motion status post total knee arthroplasty on the right. Plan:

The evaluator is going to resubmit the request for her turn-buckle brace and make it clear that she has lost range of motion and it is not to treat stability. She is perfectly stable. It is to treat contracture.

Follow-up visit with Unknown Dr., on 12-19-11 notes the claimant complains of right knee and lumbar pain. The claimant is to continue medications. (Other illegible hand written notes).

12-19-11 DO., DWC-73: The claimant was taken off work from 12-19-11 through 1-19-12.

1-23-12 DO., the claimant complains of right knee, lumbar pain. The claimant is concerned about her bladder not able to hold it at all. The claimant states that it started about a month ago. The claimant needs refill on Norco. Assessment: Lumbar HNP, right knee ID. Plan: Refill Norco. (Other illegible hand written notes). DWC-73: The claimant was taken off work from 1-23-12 through 2-22-12.

2-22-12 DO., the claimant complains of right knee, pain. Assessment: Lumbar HNP, right knee ID. Plan: The claimant was prescribed Lyrica. (Other illegible hand written notes). DWC-73: The claimant was taken off work from 2-22-12 through 3-21-12.

3-21-12 DO., the claimant complains of right knee, lower back, lower leg pain. The claimant complains of radiation of pain to lateral hip, to heels, tingling, numbness to right foot, complains of right leg cramps, swelling worse later in day. Assessment: Lumbar HNP, right knee ID. Plan: (illegible hand written notes). DWC-73: The claimant was taken off work from 3-21-12 through 4-23-12.

3-28-12, MD., the claimant complains of lumbar pain. The claimant suffers from chronic low back pain with tingling, sharp pain, and aching pain down into her buttocks, both right and left. Her pain is a 5-10. The claimant states that medications do not help the pain. In January 2009, she had a fusion of her lumbar spine but continues to have low back pain. She requests more physical therapy on her right knee. She had a right total knee by Dr. approximately a year ago. She lacks 10 degrees of full extension and has only 95 degrees of flexion. The evaluator believes more physical therapy and possible manipulation would gain her more range of motion of her right total knee. Her last radiographer requested, and the evaluator now requests also, a myelogram followed by CAT scan to her lumbar spine for neural foraminal stenosis. At L4-5, she either has hardware or disc in the right neural foramen, and her radiologist asked for the myelogram followed by the CAT scan. The evaluator agrees at L3-4, L4-5, and L5-S1. Plan: The evaluator would like to request injections for the lumbar spine and a myelogram followed by a CAT scan. Follow up in this clinic in one month.

4-17-12 MD., performed a Medical Review. In her judgment, the clinical evidence provided does not establish the medical necessity for a transforaminal epidural steroid injection. The Official Disability Guidelines, Section Low Back, Subsection Procedure Summary, Item ESI, states, "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. Radiculopathy must be documented. Objective findings on examination need to be present. Radiculopathy must be corroborated by imaging studies and/or electro diagnostic testing. Initially unresponsive to conservative treatment (exercises, physical methods, NSAIDs and muscle relaxants). Injections should be performed using fluoroscopy (live x-ray) and injection of contrast for guidance. 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. No more than two nerve root levels should be injected using transforaminal blocks. No more than one interlaminar level should be injected at one session. 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. Repeat injections should be based on continued objective documented pain relief, decreased need for pain medications, and functional response." In the case of this Claimant, there is no information as to whether Claimant has received a prior lumbar ESI or her response to injection, if previously performed. Dr. note describes "diminished deep tendon reflexes" and "a positive straight leg test on the right indicative of radiculopathy". Dr. refers to Dr. recommendation "for transforaminal epidural steroid injections at L5-S1". This L5-S1 level was suggested by Claimant's electro diagnostic study of 2010, although the lumbar MRI of 2011 described primary pathology at L4-5, and Claimant's diminution of the patellar and Achilles reflexes would also suggest involvement of the L3-4 disc area. Thus it is unclear as to the appropriate level for ESI Reviewer attempted to speak with Dr. twice on 5-2-12, as this peer-review was due morning of 5-3-12. Reviewer was unable to obtain clarification of the above questions from Dr. and for this reason, the medical necessity of a lumbar ESI and the designated ESI level could not be established. Evidence based guidelines and medical evidence fail to support medical necessity for an ESI.

4-17-12 UR performed by unknown provider notes that CT Myelogram of the lumbar spine was non authorized. He notes that there is no indication in the note of 3-28-12 that the claimant's condition is changed significantly subsequent to being discharged postop. The note of 3-28-12 seems to imply that the claimant's pain has been relatively stable, although he could not confirm this definitively. He could not confirm whether or not surgery was being anticipated. In light of the above, and given the directions

provided by the guidelines, rationale for recommendations other than adverse determination for this request cannot be generated at this time.

4-23-12, DO., the claimant complains of right knee, lower back pain. The claimant complains of radiation of pain to lateral hip, to heels, tingling, numbness to right foot, complains of right leg cramps, swelling worse later in day. Assessment: Lumbar HNP, right knee ID. Plan: (illegible hand written notes). DWC-73: The claimant was taken off work from 4-23-12 through 5-21-12.

4-25-12 DO., the evaluator noted that considering clinical and diagnostic findings, it is of medical necessity to request CT myelogram of lumbar spine for unequivocal confirmation of findings in MRI of 8-25-11. The claimant may be a candidate for surgical intervention; however, it is medically appropriate to exhaust all forms of conservative treatment. Treatment would include epidural injections at L5-S1. Please grant approval for CT myelogram and ESI.

5-11-12 MD., the claimant is a female who has severe back pain and severe pain in the right buttock, leg and thigh radiating all the way to the foot, in particular, the right knee. She injured herself on xx/xx/xx when she was standing with her back against a board in front of her class working as a. The desk fell on her right knee and she jumped backwards. She eventually underwent L4-5 effusion in 2009. Since then her back pain got a little bit better. The right leg pain has actually worsened. She has had the pain ongoing for about 6 years plus. The pain is worse when she is lying in one position, standing, walking or driving or sitting. Her pain is worse with coughing. Her pain is worse at night and it wakes her up at night. She has had no fevers, chills or night sweats. No changes of bowel or bladder. Sitting makes the pain worse for 30 minutes. Standing worsens the pain after 15-30 minutes. She has had physical therapy and chiropractic treatment, which has not given her prolonged relief. She takes Norco, which dulls the pain but does not take it away. She has undergone L4-5 fusion in the past by Dr. in January 2009. On exam, she has positive straight leg raise test on the right side. She has 4-/5 strength of right ankle dorsiflexion. Deep tendon reflexes are 2+. Patellar tendons are bilaterally absent ankle jerk on the right, 1+ on the left side. Sensory testing appears to be normal to light touch in all dermatomes. MRI shows she is status post L4-5 fusion with a cage on the right side. There are screws bilaterally at L4-5. There is the appearance of a large right foraminal lateral disc herniation compressing the right L5 nerve root, possibly the right L4 nerve root within the foramen. It is suggested that she undergo a lumbar CT myelogram. EMG of the lower extremities suggests bilateral L5 irritation right more than left. Impression: This is a female status post L4-5 TLIF now with right-sided foraminal disc herniation, intractable right leg pain and right leg weakness in the L5 and S1 distribution. Plan: Obtain plain x-ray of AP lateral, standing x-ray with flexion and extension and lumbar myelogram to further delineate the right sided foraminal disc protrusion.

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

THE CURRENT FOCUS ON THE LUMBAR SPINE APPEARS TO BE BASED ON MRI FINDINGS, WHICH SHOWS METALLIC ARTIFACT SINCE CLAIMANT HAS INSTRUMENTATION ANTERIORLY AND POSTERIORLY. THE SUSPECTED FORAMINAL DISC PROTRUSION WOULD NOT BE SEEN FROM THE MYELOGRAM COATING OF THE NERVE ROOT. THE ARTIFACT FROM INSTRUMENTATION WOULD DISTORT THE CAT SCAN FINDINGS AS THEY WOULD BE IN THE SAME SAGGITAL PLANE.

LIKEWISE, CLAIMANT HAS BILATERAL PATELLA REFLEXES WHICH ARE ABSENT. THERE ARE NO LOCALIZING EXAM FINDINGS AND ONLY SUBJECTIVE COMPLAINTS.

A LUMBAR MYELOGRAM AND CAT SCAN IS NOT LIKELY TO PROVIDE ADDITIONAL HELPFUL CLINICAL INFORMATION. THEREFORE, THE REQUEST FOR MYELOGRAPHY, LUMBOSACRAL, RADIOLOGICAL SUPERVISION, AND INTERPRETATION IS NOT REASONABLE NOR MEDICALLY NECESSARY.

ODG-TWC, last update 2-20-12 Occupational Disorders of the Low Back – Myelography: Not recommended except for selected indications below, when MR imaging cannot be performed, or in addition to MRI. Myelography and CT Myelography OK if MRI unavailable, contraindicated (e.g. metallic foreign body), or inconclusive. (Slebus, 1988) (Bigos, 1999) (ACR, 2000) (Airaksinen, 2006) (Chou, 2007) Invasive evaluation by means of myelography and computed tomography myelography may be supplemental when visualization of neural structures is required for surgical planning or other specific problem solving. (Seidenwurm, 2000) Myelography and CT Myelography have largely been superseded by the development of high resolution CT and magnetic resonance imaging (MRI), but there remain the selected indications below for these procedures, when MR imaging cannot be performed, or in addition to MRI. (Mukherji, 2009)

ODG Criteria for Myelography and CT Myelography:

1. Demonstration of the site of a cerebrospinal fluid leak (postlumbar puncture headache, postspinal surgery headache, rhinorrhea, or otorrhea).
2. Surgical planning, especially in regard to the nerve roots; a myelogram can show whether surgical treatment is promising in a given case and, if it is, can help in planning surgery.
3. Radiation therapy planning, for tumors involving the bony spine, meninges, nerve roots or spinal cord.
4. Diagnostic evaluation of spinal or basal cisternal disease, and infection involving the bony spine, intervertebral discs, meninges and surrounding soft tissues, or inflammation of the arachnoid membrane that covers the spinal cord.
5. Poor correlation of physical findings with MRI studies.
6. Use of MRI precluded because of:
 - a. Claustrophobia
 - b. Technical issues, e.g., patient size

- c. Safety reasons, e.g., pacemaker
- d. Surgical hardware

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
- 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)

