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DATE OF REVIEW: 5/10/07

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Lumbar ESI with Fluoroscopy and epidurogram

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

M.D. Board Certified in Anesthesiology and Pain Management

REVIEW OUTCOME

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

XUpheld (Agree)

Overtured (Disagree)

Partially Overtured (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

Denial reports

RME's: 4/17/07, 12/05/06; M.D.

MRI of Lumbar Spine Report 12/22/06

Electrodiagnostic Testing report; 12/18/06

Reevaluation Report 3/22/07; Dr.

Reports: 2006/2007; Dr.

Reports 2006

Operative Report 2/27/07

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient has had low back pain. The records indicate that there is evidence that activities of daily living are being performed at home and the patient is at light duty at work. The MRI shows degenerative changes and no focal nerve impingement. The pain

is in the low back with no radicular component. Depression is present and “history, physical examination and now objective data do not align itself” per the treating pain management physician. On 1/11/07, TPI was performed in the low back that was called a “facet injection.”

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

Evidence based Guidelines in the article Management of Chronic Spinal Pain (Pain Physician 2007; 10:7-111) state that translaminar ESI’s “could only be considered for radicular pain” present in this patient.

I agree with the denial. Evidence for ESI’s in the management of low back pain is indeterminate.

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 JUDGMENT, 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)
PAIN PHYSICIAN, 2007; 10: 7-111.