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DATE OF REVIEW: 7/23/09

IRO CASE #:

Description of the Service or Services In Dispute
L2-L3 L3-L4 ESI

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

Physician Board certified in Neurological Surgery

REVIEW OUTCOME

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

X Upheld	(Agree)
Overtaken	(Disagree)
Partially Overtaken	(Agree in part/Disagree in part)

Description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

ODG Guidelines

PATIENT CLINICAL HISTORY [SUMMARY]:

This case involves a xx-year-old female who in xx/xx twisted her back and knee when catching herself from falling. She has had persistent pain in her back, extending into her lower extremities. Conservative measures, including medication, have been only transiently beneficial. An 8/11/08 MRI of the lumbar spine suggests multilevel pathology without any surgically significant pathology being definitely present. An EMG report on 10/15/08 did not show radiculopathy, and was interpreted as "normal." She had ESI's, which were reported in a 6/23/09 letter as being significantly beneficial for eight months. However, in the 1/5/09 report, it would appear that the patient was having recurrent, significant pain, and this was only about 13 days after her last ESI. The increased pain was attributed to a change in medications, with Lyrica being discontinued.

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

I agree with the denial of the requested epidural steroid injections. There is nothing on examination or electrodiagnostic testing to indicate radiculopathy secondary to nerve root irritation or otherwise, and under these circumstances ESI's are frequently of no benefit. It would appear that no significant benefit was obtained from previous ESI's and to repeat those would not be indicated.

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 KNOWLEDGBASE**

- 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)**