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IRO Certificate

*Notice of Independent Review Decision*

**DATE OF REVIEW: 10/20/10**

**IRO CASE #:**

Description of the Service or Services In Dispute  
Lumbar ESI w Fluoroscopy; therapeutic exercise; therapy; neuromuscular reeducation; electro stimulation

**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:

- |   |                                  |
|---|----------------------------------|
| <input checked="" type="checkbox"/> Upheld    | (Agree)                          |
| <input type="checkbox"/> Overturned           | (Disagree)                       |
| <input type="checkbox"/> Partially Overturned | (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.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

Adverse determination letters, 9/16/10, 8/16/10, 8/13/10  
Clinical notes, Dr., July- September 2010  
MRI lumbar spine report 5/20/10  
ODG guidelines

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The patient is a male who in was lifting an aquarium, and developed low back and left lower extremity pain. X-rays were thought normal, and the patient was given ibuprofen. Because of lack of improvement, an MRI was obtained, which showed only a 3mm bulging at the L4-5 level without any significant disk herniation or forminal stenosis. An ESI in June, 2010 was of benefit for only three days. Examination suggests radiculopathy, and straight leg raising is positive on the left, and there is limitation of ROM to the left. However, there is no reflex or motor deficit, and the decreased sensation to the left lower extremity is not well-defined in regard to location and the type of testing that was done. A 7/29/10 ESI was 100% effective for one week, after which 80% of the pain returned. Another ESI is recommended with physical therapy.

**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 injection. The patient has had two injections without significant benefit. The request is for a second ESI, but according to the

records provided, in addition to the ESI on 7/ 29/10, an ESI was also performed in June 2010. The requested ESI would be the patient's third ESI. An additional ESI after little benefit from the first two would not be indicated. The patient's features suggest radiculopathy, and more testing may be of benefit. In addition, although a home exercise program could be beneficial, the requested physical therapy measures would not be indicated prior to further diagnostic testing.

**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)