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IRO Certificate

Notice of Independent Review Decision

DATE OF REVIEW 2/06/12

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Surgical injection/Lumbar Medial Branch Block; Bilateral, L3-5

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

Physician Board Certified in Anesthesiology and Pain Management

REVIEW OUTCOME

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

- | | |
|---------------------|----------------------------------|
| X Upheld | (Agree) |
| Overtured | (Disagree) |
| Partially Overtured | (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, Wrkr's Comp, 12/27/11, 11/16/11
Clinical notes: MD, Pain Team, 1/13/12 - 8/18/11
MRI, Imaging Center, 5/11/11
Physical Therapy Re-evaluation., Rehab. Services, 8/03/11
ODG Guidelines

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a individual with chief complaint of lumbar back pain radiating down the right leg. Patient was watering levees in xx/xx, and slipped and fell with lower body falling straight down while upper body twisted. Lumbar MRI done on 5/11/11 showed disk pathology at L4-5. Treatment, thus far, has been pain medication and physical therapy. The pain is located in lumbar area radiating down right leg and is made worse by any type of activity. The pain also affects the patient's sleep. Epidural injection helped leg pain, but LBP persists.

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

The ODG is met for addressing the facet joints as pain generators, but documentation is lacking as to what treatment is planned. One office visit describes therapeutic intraarticular facet injections. Another office visit mentions medial branch blocks. It is unclear whether

the proposed procedure is diagnostic (ODG met) or therapeutic (not endorsed by ODG). The clinical records in this case do not meet the ODG requirements for the requested procedure.

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)**