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IRO Certificate #4599

Notice of Independent Review Decision

DATE OF REVIEW 2/29/12

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Left L5-S1 transforaminal epidural steroid injection with fluoroscopy.

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

Physician Board Certified in Pain Management and Anesthesiology.

REVIEW OUTCOME

Upon independent review the reviewer finds that the previous adverse determination 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, 1/30/12 - 1/17/12
Adverse Determination Letter, 1/17/12
Adjustor's Notes, 2/06/12 - 9/05/12
Reconsideration Letter, 1/20/12
Clinical Notes, 1/03/12 - 7/13/09
MRI Report, 4/25/05
ODG Guidelines

PATIENT CLINICAL HISTORY (SUMMARY):

This individual sustained a low back injury on xx/xx/xx. There is persistent pain in the low back with radiation to the left lower extremity. MRI from 2005 shows bilateral L5 foraminal impingement. Physical exam stated to reveal numbness and 4/5 muscle weakness in the left lower extremity, muscle groups not specified. Previous epidurals have provided benefit which is not quantified.

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

I'm upholding the appeal based on the rationale that ODG require 50 to 70% pain relief for 6 to 8 weeks after an epidural steroid injection to endorse a second one. There is no documentation of the extent and degree of pain relief from the previous epidural steroid

injections. ODG are not met for the requested procedures, and are not reasonable or necessary.

**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)**