

Envoy Medical Systems, LP
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IRO Certificate #4599

Notice of Independent Review Decision

DATE OF REVIEW: 10/25/12

IRO CASE NO.

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Epidural steroid injection L4-5 under Fluro & IV sedation #2, 62311, 77003

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

Physician Board Certified: **Anesthesiology & Pain Management**

DESCRIPTION OF THE REVIEW OUTCOME THAT CLEARLY STATES WHETHER OR NOT MEDICAL NECESSITY EXISTS FOR EACH OF THE HEALTH CARE SERVICES IN DISPUTE.

REVIEW OUTCOME

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

Upheld	(Agree) <input checked="" type="checkbox"/>
Overtured	(Disagree) <input type="checkbox"/>
Partially Overtured	(Agree in part/Disagree in part) <input type="checkbox"/>

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Notification of Adverse Determination, 8/13/12
Acknowledgment of Reconsideration Request, 9/06/12
Reconsideration Determination, 9/13/12
Clinical Note/P/T Referral, 6/05/12; 6/18/12
Clinical Notes, 10/01/12 - 6/20/12
MRI Lumbar Spine, 5/30/12; X-ray, various, 5/28/12
Progress Notes, 8/28/12 – 5/28/12
Operative Report, 7/24/12
ODG

PATIENT CLINICAL HISTORY SUMMARY

The patient is a male who suffered a work related fall in xx/xxxx. He lost his balance and fell backwards landing flat on his back. He had acute onset of burning pain in his lower back with radiating pain into the left lower thigh extremity and numbing from the knee down. He received an epidural steroid injection and 2 weeks later, 70% pain relief was noted with increased physical activity.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND

CONCLUSIONS USED TO SUPPORT THE DECISION

I agree with the benefit companies decision to deny the requested service. Rationale: ODG require 50 to 70% pain relief at 6 to 8 weeks after the first procedure to approve a second procedure. There was an epidural steroid injection performed on 7/24/12. 70% pain relief was noted on 8/06/12, two weeks after this, but it was not fully quantitated. There was nothing in the records at 6 to 8 weeks noting 50 to 70% pain relief. Since there is no documentation to satisfy ODG, the procedure is not indicated.

DESCRIPTION AND SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION

ACOEM-AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL
MEDICINE UM KNOWLEDGE BASE

AHCPR-AGENCY FOR HEALTH CARE 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 & EXPERTISE IN ACCORDANCE WITH
ACCEPTED MEDICAL STANDARDS X**

MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

MILLIMAN CARE GUIDELINES

ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES X

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
DESCRIPTION)

OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES
(PROVIDE DESCRIPTION)