**Envoy Medical Systems, LP**
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# Notice of Independent Review Decision

**DATE OF REVIEW: 9/17/12**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**
Outpatient ASC Caudal Injection 62311

**A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION**
Physician Board Certified in **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)** | **X** |
| Overturned | (Disagree) | |
| Partially Overturned | (Agree in part/Disagree in part) | |

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

**PATIENT CLINICAL HISTORY SUMMARY**
Patient sustained an injury to his low back while lifting boxes in xx/xxxx. He underwent an L4 and L5 decompression. Therapy, medications and injections have been performed. Multiple epidural steroid injections have been performed. There are records showing at least 5 injections from 10/3/06 to 6/24/10 in the subject location. It appears that some of the injections were for diagnostic purposes. Physical therapy and home exercise have been utilized.

**ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION**
I agree with the benefit company's decision to deny requested service. Rationale: ODG do not endorse repeat epidural injections unless efficacy is demonstrated from prior injections and recommends no more than 2 in the same location. There has been no documented efficacy from at least two of the epidural injections. A caudal ESI utilizes a different approach to the same location. The ODG apply for the requested procedure, as well. It may be that another diagnostic procedure may help in identifying the root cause of the patient's difficulties.

**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)