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IRO Certificate #4599

**Notice of Independent Review Decision**

DATE OF REVIEW: 11/25/13

IRO CASE NO.

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Lumbar Epidural Steroid Injection @ L5-S1; CPT: 62311, 77003

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

Physician Board Certified in Pain Management & Anesthesiology

REVIEW OUTCOME

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

<b>Upheld</b>	<b>(Agree) <u>X</u></b>
Overtured	(Disagree)
Partially Overtured	(Agree in part/Disagree in part)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Adverse Determination Letter, Worker's Compensation, 10/16/13.  
Appeal/Reply, Worker's Compensation, 11/05/13.  
Pre-authorization Requests (3), 10/29/13, 10/11/13, 9/20/13.  
Appeal Letter/Reconsideration, 10/23/13.  
Initial Evaluation, 10/08/13; Consultation/Office Visit, (referral), 10/04/13; Consultation/Office Visit, 9/20/13.  
Imaging/MRI Reports, 9/12/13-9/04/13; Radiology Report, 9/04/13;  
MRI Lumbar Spine, Imaging, 10/28/13.  
ODG (Official Diagnostic Guide)

PATIENT CLINICAL HISTORY SUMMARY

The patient is a male who slipped and fell down some stairs (xx/xxxx) and 'landed on his feet' with an acute onset of sharp pain in the lower back. According to notes from an office visit (10/08/13), the patient complained of low back pain radiating down bilateral lower extremities, pain greater on the left than right. On examination, there was moderately restricted range of motion in lumbar flexion, extension and lateral bending, along with some tenderness upon palpation in the lower back. The patient is currently on hydrocodone and Neurontin, per office visit note dated 10/08/13.

Reconsideration letter of 10/23/13 states that the MRI findings (9/13/13) of an L5 herniated nucleus pulposus with bilateral lateral stenosis meets the criteria for corroborating MRI evidence of nerve root injury. I agree with his statement. He also states that physical exam findings document the diminished sensation over the lateral leg on the left, as well as the upper thigh, compatible with a left L5 radiculopathy.

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

**Decision:**

I agree with the benefit company's decision to deny the request for lumbar epidural steroid injection.

**Rationale:**

Per ODG, decreased sensation is not regarded as objective evidence of radiculopathy. It is a subjective finding. Objective evidence of radiculopathy is required. The criteria are not met for the requested lumbar epidural steroid injection.

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)