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IRO Certificate #4599

Notice of Independent Review Decision

DATE OF REVIEW: 8/20/13

IRO CASE NO.

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Caudal epidural steroid injection; L5-S1 (PNR Fluoroscopy IV Sedation) CPT: 62311, 77003

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

Physician Board Certified in Anesthesiology & Pain Management

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)
Partially Overtured	(Agree in part/Disagree in part)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Notification of Adverse Determination, 5/31/12;

Reviewer comments

Reply to Letter of Reconsideration, 7/15/13,

Reviewer comments

Post Designated Doctor's Required Medical Examination, 2/25/13; Comments, History & Physical Examination, 2/14/13

Clinical Notes/Follow-up Notes (5); Anesthesia,; 6/10/13 - 1/04/13; 6/14/13

Clinical Notes/Eval (4); Anesthesia, 2012; 2010

Radiology: CT of Lumbar Spine, 7/31/13; E/M4 Comp. Exam (Medical), 7/01/13; MRI Cervical Spine (Imaging), 9/13/10; Cervical ESI/Epidurogram/Cervical Spine Series (3 views) (Imaging), 11/05/10

Operative Reports (2); Procedures (5/14/13 & 1/22/13)

Operative Report (1); Procedure (12/04/12)

ODG (Official Disability Guidelines)

PATIENT CLINICAL HISTORY SUMMARY

The patient's injury occurred in xx/xxxx. She sustained an injury apparently during work hours. A caudal epidural steroid injection was performed on 5/14/13. At an office visit on 5/22/13, a clinic note indicated that her pain had been reduced by better than 70%, with improved functions and decreased medication usage.

evaluated the patient on 6/14/13, 4 weeks after the epidural steroid injection, and the patient stated she continues to have low back pain radiating down the left leg, with numbness that has worsened, since the lumbar epidural steroid injection.

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 requested procedure. Rationale:

ODG require 50 to 70% pain relief for at least 6 to 8 weeks. 4 weeks after the injection, she stated that her pain was worse. ODG are not met.

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)