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IRO Certificate #4599

### Notice of Independent Review Decision

DATE OF REVIEW: 5/31/13

IRO CASE NO.

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Cervical Epidural Steroid Injection, C3-4; CPT: 62310 77003 62264 72275

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

Physician Board Certified: Pain Management and Anesthesiology

REVIEW OUTCOME

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

Upheld (Agree)

**Overtured (Disagree) X**

Partially Overtured (Agree in part/Disagree in part)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

UR Denial Letters (3) 4/01/13, 2/04/13, 1/15/13

Reconsideration Letter, 4/12/13

UR Reconsideration Letter, 5/02/13

Letter of Medical Necessity, 4/12/13

Clinical Notes, 3/14/13; 1/17/13

Orthopedic Report, 1/17/13

Memo (2), Re: Request for Contested Case Hearing; Withdraw Request for CCH; 2/21/13, 2/26/13;

Radiology: Orthopedic Consultation/Muscle Strength Exam., 12/21/12

MRI/Diagnostic (2), Memorial MRI & Diagnostics, 10/08/12

ODG (Official Disability Guidelines)

PATIENT CLINICAL HISTORY SUMMARY

This individual sustained cervical and lumbar injury in a motor vehicle accident in xx/xxxx. Physical therapy and medications have been utilized. There is right cervical pain with radiation through the right shoulder and trapezius. An MRI shows a herniation at C3-4 with right sided C4 impingement.

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

Decision: I disagree with the benefit company's decision to deny the requested service.

Rationale:

ODG require evidence of radiculopathy as defined by alteration in the function of a nerve root or nerve roots. The diagnosis requires dermatomal distribution of pain which is present. There are also

paresthesias in the C4 distribution. There is corroborating evidence of radiculopathy on MRI which shows right sided C4 impingement. Conservative therapy has been performed. Fluroscopy will be utilized. All criteria for requested cervical epidural steroid injection have been 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) X**

NCBI – PubMed:

Spine J. 2004 Sept-Oct., 4(5); 495-505; Semin Roentgenol, 2004 Jan; 39 (1): 7-23

Articles From Journal of Bone & Joint Surgery; Vol. 89-A Supplement 3 2007

Data from 17<sup>th</sup> Annual Scientific Session; American Academy of Disability Evaluation  
November 13-15, 2003