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**Notice of Independent Review Decision**

DATE OF REVIEW: 11/14/14

IRO CASE NO.

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Epidural Steroid Injection, RT C5, C6 (Transforaminal) CPT: 64479, 64480, 72275, 01935

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

ODG (Official Disability Guidelines)

PATIENT CLINICAL HISTORY SUMMARY

This individual sustained injury in xx/xxxx. Physical therapy and medications have been utilized. An MRI on 12/09/13 was reported to show bulges at C4-5, C5-6, and C6-7 with no impingement. In August of this year, a right C7 transforaminal epidural steroid injection was requested. An office visit at that time described decreased sensation in the right C7 distribution. This procedure was denied. At a 10/24/14 office visit pain was described as being in the right C5, C6 distribution and there was decreased sensation noted. On 10/03/14 noted pain in the right posterior upper arm but no decreased sensory or motor deficit was noted. An EMG on 2/25/14 shows evidence of moderate right ulnar neuropathy and a chronic right C5-6 radiculopathy.

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

**Opinion: I agree with the denial for the requested service(s).** Rationale: The evidence based on guidelines per ODG are not met for the requested procedure. There is no evidence of acute radicular process and no corroboration of impingement is described on the MRI. ODG are not met for the requested procedure.

**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)