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Notice of Independent Review Decision

DATE OF REVIEW: 11/21/14

IRO CASE NO.

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE
LESI x 3 Bilateral L5, CPT: 64483, 64484, 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:

Upheld (Agree)

Overtaken (Disagree)

Partially Overtaken (Agree in part/Disagree in part) X

ODG (Official Disability Guidelines)

PATIENT CLINICAL HISTORY SUMMARY

The claimant is a male injured in xx/xxxx. No injury cause was noted. Upon physical examination that took place 12/13/12, noted plantar and dorsiflexion motor weakness was 3/5. A lumbar epidural steroid injection was requested at that time. During an office visit of 4/30/13 felt a second epidural steroid injection was indicated.

An MRI on 9/22/14 was reported to show clumped lumbosacral nerve roots, multilevel herniations with compression of both L4 and L5 nerve roots. The original request was for a series of three lumbar epidural steroid injections (letter of medical necessity dated 9/29/14), but only one was given and apparently the second was denied as being not supported by ODG.

Recommendation: approve request for a single transforaminal lumbar epidural steroid injection at bilateral L4 and L5.

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

Opinion: I partially agree with the denial for the requested service(s). Rationale: There is evidence of radiculopathy and evidence of nerve impingement on MRI that corroborates with the physical findings.

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)