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Notice of Independent Review Decision

DATE OF REVIEW: 10/29/14

IRO CASE NO.

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Outpatient, C5-6 Selective Nerve Root Injection w/IV Sedation, CPT: 64479, 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)

Overtured (Disagree)

Partially Overtured (Agree in part/Disagree in part)

PATIENT CLINICAL HISTORY SUMMARY

Multiple modalities have been utilized including medications and physical therapy. Several imaging studies have been performed. An MRI on 1/15/13 show bi-lateral C5-6 foraminal narrowing. Elective nerve root injection was certified on 11/25/13. An EMG shows left carpal tunnel syndrome and a physical exam reveals continued weakness of muscle strength in the deltoid and triceps.

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

Opinion: I disagree with the denial for the requested service(s).

Rationale: ODG supports/endorsees epidural steroid injections when there is evidence of radiculopathy and corresponding pathology on his bi-lateral foraminal narrowing at C5-6 and decreased muscle strength in the C5-6 and C6-7 innervated muscles. The procedure was previously denied due to the request for sedation. The ODG comments cited by the reviewer states clearly '*that there is no firm recommendation regarding sedation*'. Therefore, it is reasonable to administer sedation.

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)