

Envoy Medical Systems, LP
4500 Cumbria Lane
Austin, TX 78727

PH: (512) 836-9040
FAX: (512) 491-5145
IRO Certificate #4599

Notice of Independent Review Decision

DATE OF REVIEW: 12/06/13

IRO CASE NO.

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Therapeutic Lumbar Facet Injection, L4-S1; Outpatient, CPT: 64483

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

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Letter of Adverse Determination (with ODG/low back), Worker's Compensation, 10/29/13
Reconsideration (with ODG/low back), Worker's Compensation, 11/07/13
Clinical Notes & referral, 10/16/13, 9/18/13
MRI Lumbar Spine w/o contrast findings, 5/06/13
Post-Designated Doctor's Required Medical Examination, 9/30/13
Report of Medical Examination, 8/21/13
ODG (Official Disability Guidelines)

PATIENT CLINICAL HISTORY SUMMARY

The patient is a male who sustained a back injury in xx/xxxx. He presented to the clinic for a low back pain evaluation. He is currently being treated for chronic low back pain and lower extremity radiculopathy. Patient has had physical therapy without any improvement. He has some improvement with Norco. Patient has not had injection therapy.

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

Decision:

I agree with the decision to deny the requested service/procedure.

Rationale:

A medical examination (8/21/13) indicates the patient has received physical therapy with minimal relief. Diagnosis is a lumbar strain. ODG require diagnostic epidural steroid injections limited to patients with low back pain that is non-radicular. There is documentation of radicular pain. Given the radicular findings,

ODG are not met for the requested procedure. Recommendation: Non-Certified.

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)