

Envoy Medical Systems, LP
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IRO Certificate #4599

Notice of Independent Review Decision

DATE OF REVIEW: 12/12/13

IRO CASE NO.

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Bi-lateral C2-C4 Medial Branch Blocks, 64483 (ESI), 99144 (moderate sedation services),
77003 (fluro)

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) X

Partially Overtured (Agree in part/Disagree in part)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Adverse Determination Letters/Reconsideration (2), 11/25/13, 10/02/13

Rationale for Pre-Auth., 10/02/13

Peer Review, 10/08/13

Claims Evaluation, 11/05/13

Clinic Notes: 11/08/13-7/03/13; Health Record/Toxicology Rpt., 8/19/13

Cervical Spine MRI Radiology Rpt, 6/27/13

Operative Procedure: C7-T1, Intralaminar Epidural Steroid Injection, 9/12/13

ODG (Official Diagnostic Guidelines)

PATIENT CLINICAL HISTORY SUMMARY

This is a male who sustained an injury in xx/xxxx. Claimant was diagnosed with left shoulder pain and cervical disc disease with a herniated disc. An MRI of the cervical spine on June 27, 2013 documented these findings. There is radicular pain, but states that the cervical pain is primary. There should be evidence of a formal plan of rehabilitation and chiropractic rehab has been recommended. Earlier reviewers have opined that the radicular pain includes performing diagnostic medial branch blocks, but as mentioned above, there is consistent axial, cervical pain.

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

Decision:

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

Rationale:

ODG states clinical presentation should be consistent with facet joint pain, signs, and symptoms and this criteria is met. ODG for the requested bi-lateral medical branch block at C2-C4 are 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)