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IRO Certificate #4599

Notice of Independent Review Decision

DATE OF REVIEW: 5/21/14

IRO CASE NO.

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Translaminar Lumbar Epidural Steroid Injection

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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

PATIENT CLINICAL HISTORY SUMMARY

Claimant was injured in xx/xxxx. She sustained neck, back, right shoulder, right wrist, left hand, right hip and back injuries. Physical therapy and medications have been provided. She has persistent low back pain with decreased ROM (range of motion) and weakness in the left extensors, flexors, and extensor hallucis longus. An MRI shows an annular tear at L5 producing mild central stenosis at L5-S1. Previous reviewers denied the procedure based on lack of documentation of level and/or side for the procedure. replied that since the approach is translaminar, the material spreads over several levels so a particular side and/or level are not necessary.

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

Opinion

I disagree with the benefit company's decision to deny the requested service.

Rationale

ODG are met for the requested procedure. There is documented radiculopathy, failure of conservative care, and corroboration of the physical findings with the MRI pathology. I agree that a translaminar approach done in the area should provide coverage to the levels involved. A specific level and/or side are not necessary.

DESCRIPTION AND SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION

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)