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IRO Certificate #4599

**Notice of Independent Review Decision**

DATE OF REVIEW: 3/06/14 (Amended 3/10/14)

IRO CASE NO.

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Lumbar Epidural Steroid Injection @ Left L4-5, L5-S1, CPT: 62311; Transforaminal Lumbar Epidural Steroid Injection @ Left L4-5, L5-S, CPT: 64483; Addtl. Level, CPT: 64484; Epidurography, CPT: 72275; X-Ray Lumbar, CPT: 72020; Anesthesia, CPT: 01936.

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:

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

INFORMATION PROVIDED TO THE IRO FOR REVIEW

PATIENT CLINICAL HISTORY SUMMARY

The patient is a male who sustained a work related injury in xx/xxxx. There is persistent low back and left leg pain. Physical therapy has been performed, as well as 2 previous epidural steroid injections (2/16/09 & 10/14/09) which were of benefit. An MRI on 12/17/13 was reported to show moderate spondylosis, severe left, moderate right, foraminal narrowing at L5-S1. Physical exam on 1/28/14 reveals no evidence of radiculopathy.

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

**Opinion:**

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

**Rationale:**

ODG (Official Disability Guidelines) require evidence of radiculopathy for approval of an epidural steroid injection. There is no documentation of radiculopathy. ESI criteria are not 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)