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Notice of Independent Review Decision

DATE OF REVIEW: 8/19/14

IRO CASE NO.

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE
Caudal Epidural Steroid Injection at L5-S1, CPT: 62311, 72275.26

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) <u>X</u>
Overtured	(Disagree)
Partially Overtured	(Agree in part/Disagree in part)

ODG (Official Disability Guidelines)

PATIENT CLINICAL HISTORY SUMMARY

The patient sustained a lifting injury in xx/xxxx. Chiropractic had been provided and physical therapy was of no benefit. An MRI (10/08/13) showed mild to moderate central canal stenosis. There is no focal herniation. The most recent physical exam in the records presented was in an office visit on 9/18/13. At that visit there was no documentation 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 require evidence of radiculopathy that corroborates with MRI findings. There are no focal lesions on MRI nor is there evidence of radiculopathy. Evidence based guidelines are not met for the requested procedure.

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)