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Notice of Independent Review Decision

DATE OF REVIEW: 12/23/14

IRO CASE NO.

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Right Cervical ESI (Epidural Steroid Injection) @ C7-T1 (in office); CPT: 62310, 77003, J3301, J2250, 01992

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)

PATIENT CLINICAL HISTORY SUMMARY

Injury occurred after a work related incident in xx/xxxx. Physical therapy worsened the pain which is primarily in the cervical area and radiating to the right upper extremity. An office visit on 7/21/14 resulted in motor weakness being described in the right upper extremity. On 5/19/14 a CT myelogram was reported to show a C7-T1 herniation with right C8 compromise. A transforaminal cervical epidural steroid injection on the right at C7-T1 was performed on 9/15/14. On 10/13/14 during the office visit, described that the patient achieved no relief. At a previous office visit on 10/03/14 also reported no relief. At an 11/04/14 office visit, reported greater than 50% pain relief.

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

Opinion: I agree with the denial for the requested service(s).

Rationale: ODG require at least 50% pain relief at 6 to 8 weeks after the procedure and documentation of radiculopathy. There is inconsistent reporting regarding efficacy of the procedure. There were 3 office visits after the 9/15 procedure two of which described no relief from the procedure. The required 50% pain relief criteria are not met. Also, there is no physical examination documenting radiculopathy.

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)