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IRO Certificate

Notice of Independent Review Decision

DATE OF REVIEW: 4/08/15

IRO CASE NO.

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

L4-L5 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) <u>X</u>
Overtured	(Disagree)
Partially Overtured	(Agree in part/Disagree in part)

PATIENT CLINICAL HISTORY SUMMARY

This male sustained a work related injury in xxxx. Extensive therapy has been provided. An MRI in December, 2014, was reported to show left L4 and L5 root impingement. At a physical examination in November, 2014, there was decreased motor strength noted in the right leg. Previous epidural steroid injections were performed on 10/10/12 and and 6/04/12. Notes indicate that only temporary relief occurred after these procedures.

On a 1/07/15 office visit, did not document radiculopathy. note on 2/19 also did not indicate presence of physical exam evidence of radiculopathy. stated in his appeal of 3/06/15 that there was left radiculopathy, but he did not indicate specifics.

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 L5-L5 epidural steroid injection.

Rationale: ODG require at least 50% pain relief for 6-8 weeks after an epidural steroid injection to warrant approval of a repeat procedure. There is no documentation that this occurred. Evidence based guidelines for an ESI require evidence of radiculopathy and the patient's last several office visits do not document presence of radiculopathy. Previous appeals noted that there was inconsistency in the MRI versus symptoms. The MRI was positive on the left; symptoms of motor weakness was on the right. This was settled: all of the symptoms were on the right side. Regardless, ODG 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 INFORMATION)