

**Envoy Medical Systems, LP**  
**4500 Cumbria Lane**  
**Austin, TX 78727**

**PH: (512) 705-4647**  
**FAX: (512) 491-5145**  
**IRO Certificate #4599**

DATE OF REVIEW: 1/25/16

IRO CASE NO.

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Lumbar Epidural Steroid Injection under anesthesia with fluoro guidance (level unknown) CPT 62311

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION

Physician Board Certified in Physical Medicine & Pain Management

REVIEW OUTCOME

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

<b>Upheld</b>	<b>(Agree) <u>X</u></b>
Overtaken	(Disagree)
Partially Overtaken	(Agree in part/Disagree in part)

PATIENT CLINICAL HISTORY SUMMARY

Patient is a female who sustained a back injury in XX/XXXX when she was driving and it was struck by another vehicle. Lumbar MRI from XX/XX/XX showed broad based disc herniation at L5-S1 and moderate L4-5 central and foraminal stenosis. CT of the lumbar spine XX/XX/XX showed L4-5 degenerative listhesis with large extradural defect and posterior narrowing with high grade stenosis within the canal. Apparently, she did undergo two epidural steroid injections which gave her 80% relief for 8 weeks. Her orthopedic surgeon, did document that she had lower back pain radiating into both legs with a physical exam on XX/XX/XX that showed right EHL and quad weakness, left lateral thigh and bilateral feet numbness, and right patella reflex 1+ compared to 2+ on the left. The exact injections performed by previous pain management physician is not available. She saw XX for an initial consultation after her previous pain management physician stopped accepting her insurance. XX refilled her gabapentin, Norco, Mobic, and cyclobenzaprine. He documented that she has lower back pain. His physical exam showed some tenderness of the paralumbar area and mid-line but no neurological exam was documented. (just gait WNL). Request was for translaminar ESI, epidurogram, and fluoro guidance. No level or laterality was specified.

First request was denied because the request was nonspecific and does not indicate the level/laterality to be injected. Second request was denied because most recent clinic note did not clearly reflect radicular symptoms or clinical findings 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(s).**

Rationale: This review pertains to the need for an epidural steroid injection in the context of lumbar radiculitis pain due to a herniated disc and possibly spinal stenosis.

Per ODG lumbar epidural steroid injections are recommended as a possible option for short-term treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy) with use in conjunction with active rehab efforts. Although XX did document a history and neurological exam that supports the diagnosis of radiculopathy, the requesting physician did not. (axial

back pain, no neurological exam) Furthermore, XX did not specify the level or laterality of the injection requested nor did he specify where the previous injections were given.

**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)