

Envoy Medical Systems, LP
4500 Cumbria Lane
Austin, TX 78727
DATE OF REVIEW: 2/03/16

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IRO Certificate #4599

IRO CASE NO

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Lumbar Epidural Steroid Injection, L5-S1 Right side, Outpatient between 1/11/16 and **2/25/16**

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 individual sustained a back injury in XX/XXXX. There has been persistent back pain which responded to a radio frequency rhizotomy XX/XX/XX). In an office note there was right leg pain described. EMG and NCV studies was consistent with approximal L5 radiculopathy. An MRI conducted was reported to show a right disc herniation at L4-5 with moderate right foraminal stenosis and mild right L4 compression. There is a left extra foraminal herniation at L3-4 with minimal left L3 dorsal root compression and a leftward disc herniation at L5-S1. There is no description of right L5 impingement.

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: ODG require evidence of radiculopathy that corroborates with the symptomology and with MRI findings. This individual has right leg pain and a suggestion of a right L5 radiculopathy, but the MRI show no impingement on the right at L5-S1. ODG are not met for the 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)