**Envoy Medical Systems, LP**
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**Austin, TX 78727**

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**IRO Certificate XXXX**

## Notice of Independent Review Decision

DATE OF REVIEW: 07/25/18

IRO CASE NO. XXXX

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**
Lumbar Interlaminar Epidural XX Injection (1), Left L4, CPT: 62323 (NJX Interlaminar Lmbr/Sac); XX for Spine Injection, CPT: 77003

**A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION**
Physician Board Certified in Anesthesiology & Pain Management

**REVIEW OUTCOME**

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

| | |
|---|---|
| **Upheld** | **(Agree) X** |
| Overturned | (Disagree) |
| Partially Overturned | (Agree in part/Disagree in part) |

**PATIENT CLINICAL HISTORY SUMMARY**
This XX worker sustained an injury in XX. There is low back pain radiating through the posterior left lower extremity. Treatment modalities include physical therapy and medications. Physical examination reveals neither motor nor sensory defects. MRI showed a 2.5mm diffused disc bulge at the L4-5 level displaying mild encroachment of the left L4 foramen.

**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 endorse lumbar epidural XX injections if radiculopathy is documented by objective findings: 1) Radiculopathy must be corroborated by imaging studies or electrodiagnostic testing; 2) Initially unresponsive to conservative treatment; 3) Injections should be performed using fluoroscopy. These criteria are not met; there is no objective evidence of radiculopathy and imaging studies do not reveal neural compression. The denied request is not medically necessary.

**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)