Envoy Medical Systems, LP
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IRO Certificate #XX

DATE OF REVIEW: 2/01/18

IRO CASE NO. XXXX

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Right L4-5 Transforaminal Epidural Steroid Injection

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

Patient is a XX year old XX who sustained a work related injury in XXXX. He XXXX and hyper-extended XX knee. XX has persistent pain in the right knee, left elbow, and low back. XX has completed 6 sessions of physical therapy without benefit. XX has been treated with medications. Dr. XXXX office notes are consistent in describing tenderness in the low back and intermittent paresthesia to the right leg. No neurological deficit is described. An MRI shows a 6mm central L4-5 protrusion without neural impingement. Two previous reviewers have denied the request based on ODG. The reviewers opined that there was no radiculopathy and no nerve 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.

Rationale: No additional documentation was presented to change the previous opinion. There is no evidence of neurological deficit and no impingement on MRI. 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

DESCRIPTION AND SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION (continuation)

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)