Envoy Medical Systems, LP
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IRO Certificate #XX

DATE OF REVIEW: 9/14/18

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

XX Epidural Steroid Injection, XX-XX under Fluoroscopy with XX XX, XX, XX/XX

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

Patient is a XXXX who was injured in XXXX. XXXX has undergone chiropractic physical therapy and rehabilitation and has been prescribed XX medications and co-analgesics. XXXX describes XX XX XX on examination. There is moderate XX XX tenderness, XX straight leg raising sign on the XX and XX sensation to pin prick in the XX XX. An MRI was reported to show a XX XX at XX-XX which impinges upon the XX XX XX root and XX XX the XX XX XX and XX XX. Two previous reviewers denied the request based on evidenced based guidelines which require specific objective neurological findings to meet the criteria for XX epidural XX injections. As the previous reviewers have opined, this criterion is not met; there are no objective findings to support the diagnosis of XX.

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: In the summary of reasons noted above, I agree with the benefit company that the XX 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 XX XX 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)