Envoy Medical Systems, LP
1726 Cricket Hollow Drive
Austin, TX 78758

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

DATE OF REVIEW: 02/04/19

IRO CASE NO. XX

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE
XX Steroid Injections, XX XX-XX, XX-XX and XX XX XX XX-XX, XX-XX XX XX XX, CPT: XX XX XX XX, In-office

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
The patient is a XX year old individual who sustained a XX and XX XX in XX, XX. XX has persistent XX, XX XX, and XX XX pain. XX therapy has been completed. A XX MRI (XX) is reported to show a broad based XX and XX XX XX of XX-XX with mild XX XX. There are other XX XX with no XX XX. A physical examination reveals diffuse XX tenderness and pain with all ranges of motion.

A XX MRI reveals XX changes with XX XX at XX-XX and XX-XX and a small broad based XX XX at XX-XX and XX-XX with mild narrowing XX. There is no high grade impingement reported. On physical examination, the XX XX reveals tenderness. There was poor XX to XX 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: Per ODG XX diagnostic XX XX XX require evidence of pain elicited over the XX and pain with XX loading. This individual has diffused pain and tenderness and pain with range of motion in all planes. These findings are not specific for XX pain. ODG are not met for the requested procedure.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION (continuation)
XX XX steroid injections, per ODG, require corroboration of symptoms with radiographic findings. There is no mention of XX pain; there is no high grade impingement and no evidence of XX. ODG are not met for the requested procedure.

The requested service(s) are not medically necessary for this case.

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)