

Envoy Medical Systems, LP
1726 Cricket Hollow
Austin, Texas 78758

DATE OF REVIEW 4/27/07

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Disc Arthroplasty; L5;S1

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION

M.D. Board Certified in Neurological Surgery

REVIEW OUTCOME

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

XUpheld (Agree)

Overtured (Disagree)

Partially Overtured (Agree in part/Disagree in part)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Denial letter 3/1/07 and 2/8/07

Lumbar Myelogram 11/29/06

Lumbar MRI report 10/10/06

Electrodiagnostic testing report 9/7/06

Reports 11/06–2/07 Dr.

Procedure Summary regarding low back disc prosthesis

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who developed pain in the low back which soon extended into the left lower extremity. Physical therapy and injections were not successful so low back surgery was performed in April 2006, with good relief of left lower extremity pain but the

back pain continued. The associated lower extremity pain is now primarily on the right side; It was on the left prior to surgery. Electrodiagnostic testing shows the left L5 and S1 radiculopathy of an acute nature. On examination, straight leg raising is positive on the right side. With there being weakness in the right S1 muscle distribution. An 11/29/06 lumbar myelogram showed L5-S1 bulging without any distinct surgical correctable pathology being present.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION

The EMG is positive on the left. The findings on examination are essentially confined to the right side. The patient's symptoms are on the opposite side from the side on the EMG report. There is nothing on the CT myelogram or on the MRI usually associated with surgically correctable pathology. Under these circumstances a major operative procedure would not be indicated. And that would include disc replacement.

If symptoms compatible and more consistent with areas of trouble in the lumbar spine develop, then disc replacement might be considered. I disagree with the report from the carrier that radiculopathy is an exclusion criterion for lumbar disc replacement. I also disagree with the concept of significance back pain on a "mechanical" basis as being a contraindication for the use of an artificial disc.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE
- AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES
- DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES
- EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN
- INTERQUAL CRITERIA
- MEDICAL JUDGMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS
- MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

- MILLIMAN CARE GUIDELINES**
- ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**
- 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 A DESCRIPTION)**
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**