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IRO Certificate

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: 8/22/07

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Interbody fusion L5-S1, retroperitoneal exposure and discectomy L5-s1 with anterior interbody fixation and Cybertech TLSO

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:

- | | |
|---|----------------------------------|
| <input checked="" type="checkbox"/> Upheld | (Agree) |
| <input type="checkbox"/> Overturned | (Disagree) |
| <input type="checkbox"/> Partially Overturned | (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

Table of Disputed Services
Denial Letters 7/12/07, 7/24/07
Reports 10/23/05, 5/10/07, Dr.
Notes 1/24/07 – 7/20/07, Dr.
Psychological evaluation 7/5/07, Dr.
Lumbar MRI report 8/23/03
Lumbar discography report 10/8/03
Physical therapy notes
URA report 3/1/04, Dr.
Notes and ESI evaluation 2004, Dr.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a xx-year-old female who developed severe low back pain in association with working in a bent position. The low back pain was joined by lower extremity pain about a year after the onset of her trouble. The pain continued despite physical therapy, medications and rest. MRI evaluation on 8/23/03 suggested a small, only possibly surgically significant midline L5-S1 disk rupture. The degree of rupture was not thought to be surgically significant, and showed nothing to suggest significant spinal cord stenosis or nerve root compression. Discography on 10/8/03 Was positive at the L5-S1 level only. Epidural steroid were only transiently beneficial. A 7/20/07 note by the spine surgeon indicates that he thinks repeat MRI and discography is indicated.

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

I agree with the benefit company's decision to deny the requested surgery and bracing. There is nothing to suggest a specific radiculopathy on examination or imaging studies, and nothing to suggest instability in the lumbar spine. The surgeon is at a point where he thinks additional testing is also indicated before proceeding with a surgical intervention.

This opinion does not diverge from ODG guidelines.

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)**