
**ENVOY MEDICAL SYSTEMS, LP
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Notice of Independent Review Decision

DECEMBER 10, 2007

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Pro-disc @ L4-5 & ALIF @ L5-S1 LOS 2

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

M.D. Board Certified Neurological Surgeon

REVIEW OUTCOME

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

- Upheld (Agree)
 Overturned (Disagree)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Review/Denial Letters – 11/7/07
Notification of Determination Letter – 10/5/07
Lumbar Discography Report – M.D. 9/21/06
MTI Lumbar Spine Report – Imaging – 9/22/05; 6/2/04
Electrodiagnostic Testing Results – 9/22/05
Clinical Reports – 2004 – 2007
Clinical Report – M.D. 7/11/06\
Psychological Testing Reports – Ph.D 9/19/07
ODG Guidelines

PATIENT CLINICAL HISTORY [SUMMARY]:

This case involves a male who developed low back when he was taking a 250-gallon water heater to an attic. He has continued work with his pain and continued with conservative management. The pain now extends into the lower extremities, primarily on the left side but his back pain is the most prominent pain. Examination has failed to reveal any reflex sensory or motor deficit but straight leg raising is positive on the left. Psychological testing has cleared him for surgery on 9/19/07. MRI's on 9/27/05 shows changes of chronic nature at both the L4-5 and L5-S1 with possible disc herniation of significance at the L4-5 level. Electrodiagnostic testing failed to reveal any evidence of nerve root pathology, secondary to pressure or otherwise.

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 proposed 2 level operative procedure of fusion and disc replacement. No testing indicates nerve root pathology as a source of patient's trouble, and the primary discomfort is in his back. No testing indicates instability at any of the proposed operative sites. The MRI results and discography results on which this operation is being proposed were done over 1 year ago and were "without lateralization" despite the patient's lower extremity discomfort primarily being on the left side. In addition, electrodiagnostic testing has failed to reveal evidence of nerve root compression, which is one of the clinical features usually present when disc replacement is recommended. With the information provided thus far, I agree with the denial.

This decision does not diverge from the 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 JUDGEMENT, 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)**