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IRO Certificate #

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: 6/22/07

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Endoscopic carpal tunnel release

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

M.D. Board Certified

REVIEW OUTCOME

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

XUpheld (Agree)
Overturned (Disagree)
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

Denial letters 5/10/07, 5/17/07
Report 5/16/06, Dr.
Pain management reports 5/05 –2/07
Reports, Dr. 2006
Reports 2005 – 2006, Dr.
Letter 4/5/07, report initial office visit 1/23/07 Dr.
MRI lumbar spine reports 1/12/05, 3/20/06, 3/31/06
Lumbar discogram an CT report 2/26/07
EMG/NCV report 2/16/05

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a female flight attendant who in xx/xx/xx was placing luggage in an overhead rack when the luggage fell, and she twisted her back and developed low back pain. The back pain has continued, with extension into both posterior hip regions, despite considerable therapy. Chiropractic treatment was unhelpful initially, and an MRI on xx/xx/xx showed chronic changes, primarily at the L4-5 level, suggesting disk herniation of a surgical nature. A xx/xx/xx EMG showed no evidence of radiculopathy. Pain management led to sacroiliac injections, facet blocks and an epidural steroid injection, with only transient benefit from the facet blocks. The patient continued with physical therapy and medications, and bracing was used at one time. A 3/31/06 repeat MRI showed the L4-5 level as the primary possible source of difficulty, and it was more pathologic in appearance than on the original MRI. The patient's examination revealed negative straight leg raising, and no reflex, sensory or motor deficits. Lumbar discography with CT scanning on 2/26/07 was strongly positive at the L4-5 level both on film and the production of concordant pain.

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

The proposed surgical procedure would not be medically necessary in this case unless a lumbar myelogram with flexion and extension, views with special attention to the L4-5 level, indicates instability or nerve root compression

The patient has findings on discogram and MRI to suggest that the L4-5 level may have correctable surgical pathology that would be dealt with by decompression and fusion. In addition, the patient has had a prolonged course without benefit from conservative treatment, and has been unable to work for over two years because of persistent discomfort.

However, the patient has negative straight leg raising and no reflex, sensory or motor deficit, and under these circumstances, an operative procedure is more frequently associated with failure.

If lumbar myelography and repeat EMG were negative, then surgery would not be necessary. If, however, pathology is seen in the form of instability, or evidence of nerve root compression at the L4-5 level, then the proposed surgery would be medically necessary.

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)**