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DATE OF REVIEW: 10/3/2007

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

TLIF L4/5, L5/S1 w/Posterior Spinal Fusion L4/S1, Inpatient LOS x 3 days

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

M.D. Board Certified in Neurosurgery

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

Insurance Co. Letter of Response to Services – 9/13/07

Insurance Co. Utilization Review Findings – 8/14/07 and 8/30/07

X-ray Report – Lumbar Spine – 5/10/04; 5/14/04

MRI Report – Lumbar Spine – 5/11/04

CT Scan Report – 5/12/07

Lumbar Discogram and CT – 2/21/06

Lumbar Myelogram and CT - 7/12/07

Clinical Reports – 11/05 through 8/6/07

Designated Doctor Evaluation – M.D. 7/10/06

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who had a truck accident and developed back and lower extremity pain primarily on the left side. This pain has persisted despite physical therapy, chiropractic treatments, injections and medications. Spine x-rays did not show significant pathology. A CT scan was also done at that time and was essentially negative, showing only chronic change. Lumbar discography in February 2006 did not show any specific area of pathology, with concordant pain being inconclusive. A lumbar CT myelogram in July 2007 showed deficits primarily at the L4-5 level with central stenosis possibly secondary to disc protrusion, and a 3 mm left sided L5-S1 defect possibly impinging on both the L5 and S1 nerve roots. A major operative procedure including transforaminal lumbar interbody fusion of the L4-5 and L5-S1 and posterior spinal fusion along with decompression has been proposed.

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 operative procedures. There is no instability on examinations or on imaging studies. There is no reflex or motor deficit and only some questionable sensory deficits, without any definite dermatome involved in the left lower extremity. Unusual lumbar disc pathology producing symptoms secondary to disc rupture or other changes is rarely at more than one level. To subject the patient to a major operative procedure at more than one level with the risk of complications is not indicated. If evidence of a specific left sided nerve root involvement could be obtained on examination, or possibly electrodiagnostic testing, then exploration with decompression of the L5-S1 nerve roots could be a more logical approach to the patient's problem from a surgical standpoint.

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)**