Envoy Medical Systems, L.P. **PH: (512) 248-9020**
1726 CRICKET HOLLOW DR. **FAX: (512) 491-5145**
AUSTIN, TX 78758

Notice of Independent Review Decision

APRIL 28 , 2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

LAMINECTOMY, FACETECTOMY AND FORAMINOTOMY

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION
Board Certified in Neurological Surgery

REVIEW OUTCOME

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

X Upheld **(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

Table of Disputed Services
Consideration Letters – 3/21/08; 4/7/08
Professional Reviews – Determination Letter – 3/21/08; 4/7/08
Lumbar MRI Reports – 11/16/06, 10/24/07
Lumbar spine Operative Report – , 2/15/07
Lumbar CT Myelogram Report 2/18/08
Orthopedic Center Reports – M.D. – 5/30/07; 9/17/07

EMG/NGV Consult Notes – M.D.
Clinical Reports – M.D. 12/7/07; 2/26/08
ODG Guidelines

PATIENT CLINICAL HISTORY: SUMMARY OF EVENTS:

This case involves a xx-year-old male who injured in xx/xx. He fell 4-5 feet from scaffolding. Medications, physical therapy and "conservative measures" were carried out for several years. But the patient continued to have intermittent discomfort in his low back and into his right lower extremity. The right lower extremity pain became more severe in 2006 and lumbar CT scanning on 11/16/06 showed L5-6 grade 1 spondylolisthesis with pars defects and spondylosis. Resumption of conservative measures was unsuccessful in dealing with his trouble and on 2/15/07, decompression hemilaminectomy on the right side at L4-5 and L5-6 was carried out. It has been determined that the patient has 6 lumbar vertebrae. The patient got only minimal relief and his discomfort became more severe in recent months extending once more into the right lower extremity. Electromyography evaluation show right L5 acute and sub acute abnormalities suggesting radiculopathy. A repeat MRI on 10/24/07 shows L4-5 spondylolisthesis with L4-5 scarring. This was confirmed by a CT lumbar myelogram on 2/18/08. This has led to the recommendation for a repeat right-sided L4-5 decompression operation.

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 this operative procedure. The patient has scarring which is a probable contributable factor to his discomfort along with the possibility of instability associated with his bony defects. A repeat of essentially the same operation he had the first time would probably lead to some very transient improvement with reformation of scar and potential instability causing recurrence of pain and therefore the operative procedure would be considered unsuccessful. With the pars defects and probable instability present, it is unlikely that a procedure that does not include fusion with discectomy would be successful in dealing with the patient's problems.

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**
- X **MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**
- ☐ **MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**
- ☐ **MILLIMAN CARE GUIDELINES**
- X **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)**