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Notice of Independent Review Decision

MARCH 11, 2007

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Tizanidine

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

M.D. Board Certified Neurological Surgery

REVIEW OUTCOME

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

- | | |
|----------------------|----------------------------------|
| Upheld | (Agree) |
| X 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

Letter– 10/9/07
Letter of Medical Necessity –Neurology Assoc. 10/22/07
Progress Note –Neurology Assoc, - 10/8/07 –1/14/08
Electromyography Report – 11/6/07
Required Medical Examination Report – 5/12/07

Patient Clinical History SUMMARY OF EVENTS:

This case involves a xx year-old female who in xx/xx slipped and fell developing back and neck pain. The pain soon became consistent in the low back and extending in the left lower extremity and continues to do so. The patient has had physical therapy and epidural steroid injections without benefit. Electromyography indicates a chronic L5 nerve root problem compatible with continued discomfort. Discography was performed but did not reveal any findings that would suggest a lumbar operation. Lumbar surgery was recommended at one time but this was never approved.

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

1. I disagree with the benefit company's decision to deny treatment for continued treatment using Zanaflex (Tizanidine). The patient has findings on various studies including most recently electromyography that indicate continued nerve root irritation may be the source of her trouble and under these circumstances, the use of a muscle relaxant is often helpful even if no obvious muscle spasm is present. The intermittent discontinuation of muscle relaxants is indicated with the presumption of such medications only if the discomfort increases significantly.

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)