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Notice of Independent Review Decision

**MAY 18, 2008**

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

TRANSFORAMINAL LUMBAR FUSION @ L4-5

**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:

<b>X Upheld</b>	<b>(Agree)</b>
Overtured	(Disagree)
Partially Overtured	(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

Notification of Determination –3/7/08, 4/4/08

Independent Medical Evaluation Report — 1/29/08

Report of Medical Evaluation – M.D. 9/4/07

Operative Report – ESI and interpretation of epidurogram– 5/9/07; 8/1/07

Lumbar CT Discogram Report – 8/1/07

MRI Lumbar Spine – 3/9/07  
ROM & MMT Evaluation – 3/28/07  
Letter of Request for Outpatient PT/PM&R – M.D. 2/15/07  
Clinical Report-- 9/21/07  
Initial Examination Report – 2/5/08  
Follow Up Consultation Notes –M.D. 5/9/07 – 4/23/08  
ODG Guidelines

**PATIENT CLINICAL HISTORY: SUMMARY OF EVENTS:**

This case involves a female who was injured while lifting trash. While in a twisted position, the patient developed back and lower extremity pain. Pain has persisted despite medications, physical therapy and epidural steroid injections. Pain now extends into the posterior right thigh also. Lumbar MRI on 3/9/07 showed a L4-5 broad based disc extending to the right side with foraminal narrowing on the right side. Lumbar CT discography done on 8/1/07 was negative at L3-4 and L5-S1 but showed significant change on CT scanning at C4-5 and also produced concordant pain at that level. There is no evidence of instability on any of the tests and only slight evidence at examination completed by Dr.

**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 transforaminal lumbar fusion at L4-5. There is no significant evidence on the imaging tests or otherwise of instability for which fusion might be helpful. The present material reviewed shows that fusion is not indicated.

**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)**