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## **Notice of Independent Review Decision**

**DATE OF REVIEW:** 4/1/09

**IRO CASE #:**

Description of the Service or Services In Dispute  
MRI lumbar spine without contrast

### **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)

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**

Adverse determination letters 3/3/09, 2/13/09  
Office visit notes, Dr. 2008 –1/26/09  
Consult report 1/14/09 Dr.  
Reports, Dr. 2007 – 2008  
Reports, Dr. 2006-2007  
Operative report facet injections, Radiofrequency reports 2006, Dr.  
4/28/08 RME, Dr.  
Lumbar MRI report 7/31/07  
1/15/05, Dr.  
ODG Guidelines

### **PATIENT CLINICAL HISTORY [SUMMARY]:**

The patient is a female who in xxxx felt a pull and strain in her back while walking down the stairs of a bus. An MRI showed degenerative disk disease changes at L4-5 with some question of disk rupture at that level also. Physical therapy, medications and various injections helped, but she continues to have significant discomfort. The pain extends into her left lower extremity. On examination there is nothing to suggest radiculopathy. A 7/331/07 MRI shows changes at the L4-5

level, along with a right-sided hemangioma. The patient was able to return to work at full duty in xxxx. She continues to have pain in her low back extending intermittently into her left lower extremity.

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

I agree with the denial of the repeat MRI of the lumbar spine. There is no change in signs or symptoms since the 7/31/07 report, which was not particularly helpful in coming to conclusions about therapeutic measures. An MRI should not be undertaken without evidence of radiculopathy such as on an EMG and the patient's understanding that an operative procedure might be necessary to deal with her trouble and that such procedure might not be helpful.

**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
- AHCPH- 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)**