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**Notice of Independent Review Decision**

**DATE OF REVIEW:** 8/5/09

**IRO CASE #:**

Description of the Service or Services In Dispute  
Revision surgery at L4-S1 with removal of instrumentation and exploration at L3/4 with anterior cages and posterior instrumentation

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

Physician Board certified in Neurological Surgery

**REVIEW OUTCOME**

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

Upheld	(Agree)
<b>X Overturned</b>	(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, 7/8/2009, 7/9/2009, 7/15/2009  
April, June 2009 notes Dr.  
Notes, Dr. March 2009  
Notes, Dr. March, May, July 2009  
4/15/09 note, Dr.  
Notes 2004 - 2005, and 7/19/05 operative report, Dr.  
CT discography and CT scan reports of the lumbar spine 2005  
Operative report discography 4/21/05

ODG guidelines

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The patient is a female who in xx/xxxx developed back pain . Physical therapy, medications and rest were not successful in dealing with her trouble. An MRI and discography suggested L4-5 and L5-S1 difficulties, with disk herniation and chronic changes. On 7/19/05 an L4-5 and L5-S1 discectomy was carried out, along with fusions with instrumentation. There was no significant improvement and the patient has continued to have back difficulties despite more surgery. Imaging studies led to difficulties suggesting correctable pathology, and on 3/708 a pseudorsrthrosis correction at L4-5 was performed, along with removal of a bone stimulator. No significant improvement followed that operation, and the patient continues to have discomfort in her back and into her lower extremities. Although I do not have x-ray reports by the

radiologist, the patient's surgeon indicates that recent x-rays with flexion and extension views show a rather severe spondylolithesis at L3-4 above the areas of fusion, along with instrumentation with anterior vertebral penetration of pedicle screws.

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

I disagree with the denial of the requested surgery. While the x-ray report is not available, the surgeon's report indicates that there is stability at the L3-4 level where the spondylolisthesis is present, but the degree of spondylolithesis probably indicates the presence of some instability, despite that not being seen on the flexion and extension views. In addition, the hardware is in an apparently changed position, which is compatible with it producing symptoms. The removal of that hardware would probably be beneficial in relieving her back pain, and may prevent more complications in the future due to the positioning of screws anterior to the vertebral bodies. While the hardware removal is being pursued, it would be poor judgment not to deal with the spondylolithesis at the L3-4 level of the fusion.

**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)**