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IRO Certificate

**Notice of Independent Review Decision**

**DATE OF REVIEW:** 7/9/09

**IRO CASE #:**

Description of the Service or Services In Dispute  
Physical therapy 3 x 4 weeks lumbar spine

**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)
Overtured	(Disagree)
<b>X Partially Overtured</b>	(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, 3/27/09, 4/28/09  
Physical therapy evaluation 3/2/09, Dr.  
Notes 6/25/08 – 6/1/09, Dr.  
Pain Management notes 4/07- 5/08, Dr.  
Lumbar spine x-ray report 3/4/08

ODG Guidelines

**PATIENT CLINICAL HISTORY [SUMMARY]:**

This case involves a male who in xx/xxxx was injured. The exact nature of the injury and the initial symptoms are not reported in the records provided for this review. The patient underwent a lumbar laminectomy with L5-S1 interbody fusion in 2003. Hardware was removed in 2005. No surgical reports were provided. The patient has continued back and lower extremity pain, with one report indicating that the back pain is 75%, and lower extremity pain 25%. He continues on a home exercise program, and has not had more former physical therapy in over one year.

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

I agree in part and disagree in part with the denial of the requested physical therapy. The records provided do not show that therapy 3 x 4 weeks would be medically necessary to deal with the patient's trouble. A shorter period of one week may be helpful in redirecting the patient's home exercise program and general activities that could reduce his discomfort. Therefore, I disagree with the denial of one week of physical therapy, and agree with the denial of more than one week of physical therapy.

**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)