

Envoy Medical Systems, L.P.
1726 Cricket Hollow Dr.
Austin, TX 78758

PH: (512) 248-9020
FAX: (512) 491-5145

Notice of Independent Review Decision

DATE OF REVIEW: 11/20/09

IRO CASE #: 23519

Description of the Service or Services In Dispute
L2-3 diskectomy, L4-5 fusion

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:

<input checked="" type="checkbox"/> Upheld	(Agree)
<input type="checkbox"/> Overturned	(Disagree)
<input type="checkbox"/> 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, 10/7/09, 10/14/09
Initial evaluation report 10/22/09, Dr.
Reports, Dr. 7/09, 9/09
Reports 6/2/09 5/14/09 Dr.
Electrodiagnostic testing reports 8/6/09
Lumbar MRI report 5/28/09
ODG guidelines

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male, who in xx/xxxx fell and developed back pain that soon extended with numbness and tingling into the right lower extremity. There is a history of lumbar laminectomy at the L5-S1 level in January 2001. Rest, medications and physical therapy were not successful in dealing with the trouble, and a 5/28/09 MRI showed a large right L2-3 disk rupture corresponding to his symptoms, and suggested difficulties including spondylolsthesis of the L5-S1 level, changes at L4-5 and to a lesser extent L3-4. CT myelography with flexion and extension views were recommended, but the records do not indicate that that has been done. EMG on 8/6/09 was normal, showing no evidence of radiculopathy.

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

I agree with the denial of the requested services. The diskectomy at the 2-3 level alone is indicated, as evidenced by the patient's signs and symptoms, and the MRI report of a large disk rupture on the right side corresponding to his symptoms. The fusion is not indicated as there is nothing on any examination suggesting instability at the L4-5 joint, and in addition, the changes adjacent, both superior and inferior to that joint, would probably be aggravated by the fusion. The recommended CT myelogram with flexion and extension views might be helpful in coming to conclusions regarding fusion, but there is no record that that has been accomplished.

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)**