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Notice of Independent Review Decision

DATE OF REVIEW: 9/19/09

IRO CASE #:

Description of the Service or Services In Dispute
bone growth stimulator

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, 2/17/09, 7/20/009, 8/18/09
Letter 8/3/09, notes 4/08 – 7/09, Dr.
Lumbar spine x-ray report 8/11/09
Lumbar CT discogram report 11/20/08
Report 8/8/09, Dr.
Electrodiagnostic testing report 5/7/08
Lumbar MR report 11/16/07
12/18/09 operative report
ODG guidelines

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who in xx/xxxx missed a step and fell. He developed lumbar spine pain with some left lower extremity pain. A lumbar MRI showed a small L4-5 disk herniation, but a significant change was grade 1 spondylolisthesis at the L5-S1 level. Conservative measures, including ESI's failed to relieve his trouble. An EMG indicated L5 and S1 nerve root irritation. With both his MRI and a lumbar discogram showing L5-S1 as a probable source of his difficulty, on 12/18/08 an anterior lumbar fusion was carried out at the L5-S1 level. The patient has continued with back pain, although notes of 7/22/09 indicate that the patient was doing better.

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 bone growth stimulator. The patient is now xxxx since his operative procedure, and if pseudoarthrosis has developed, a bone stimulator would be of very little benefit. In addition it is indicated in notes that the patient is doing better, and waiting more time to see if there is improvement is indicated, especially since on x-ray the patient's spine is in good position with the hardware functioning well and maintaining stability. If the patient's discomfort continues, especially if it is associated with left lower extremity pain, then reevaluation might be necessary.

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)