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**Notice of Independent Review Decision**

**DATE OF REVIEW:** 10/8/09

**IRO CASE #:**

Description of the Service or Services In Dispute  
lumbar CT myelogram

**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:

|                     |                                  |
|---------------------|----------------------------------|
| <b>X Upheld</b>     | (Agree)                          |
| Overtured           | (Disagree)                       |
| Partially Overtured | (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, 9/24/09, 8/28/09  
Orthopedic reports 1/09-9/09, Dr.  
Consultation report 8/19/09, Dr.  
Lumbar MRI report 7/17/09, 3/5/08  
CT lumbar myelogram 1/15/09  
3/16/09 Operative report, Dr.

**PATIENT CLINICAL HISTORY [SUMMARY]:**

This case involves a male who was injured in xx/xx while he was bending over and developed back pain. There is a history of a xxxx back injury, which cleared with physical therapy and medications. Therapy and medications were not successful in dealing with his present problems and an MRI performed 3/5/08 suggested possible surgically correctable pathology at the L4-5 level. The patient's back and lower extremity pain, primarily on the right side, continued, and this led to a 3/16/09 lumbar laminectomy at the L4-5 level, with bilateral disk herniation removal. The patient has done poorly post-operatively, and has now developed more pain in the left lower extremity, and in addition, considerable clumsiness and falling, and numbness and burning sensation at the bottom of his feet. It is also noted that ankle clonus is present, suggesting upper motor neuron disease.

**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 CT lumbar myelogram. The 7/17/09 post operative MRI, which was performed on 7/17/09 should be adequate in coming to conclusions about any problem

that has recurred in the lumbar spine that would account for the patient's symptoms. His signs and symptoms relate to possible problems in the neck or brain, which would not be found on a lumbar CT myelogram.

**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)**