

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: 1/25/10

IRO CASE #:

Description of the Service or Services In Dispute
Hardware removal , ACDF C3-4, C4-5

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:

X Upheld	(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, 12/7/09, 12/6/09, 11/23/09, 11/20/09
Notes 10/22/09, 2003, Dr.
Electrodiagnostic testing report 6/9/03
CT myelogram reports 6/29/09, 6/16/03
Operative report 9/30/03
Radiology report 10/30/03
MRI report 5/25/03, 6/16/03
ODG guidelines

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a female, who was injured with recurrent neck pain developing in xx/xx. The nature of the injury is not described in any of the reports provided for this review. There was pain radiation with tingling and numbness and a feeling of weakness in both hands. On examination there was no reflex, sensory or motor deficit, and there was nothing suggesting myelopathy. Epidural steroid injections, physical therapy and medications were not helpful. A cervical myelogram on 6/29/09 and showed "mild" spondylosis at C3-4 and C4-5. The hardware was stable and the spinal cord was without compression. The report indicated "no canal or significant foraminal stenosis is identified."

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

I agree with the decision to deny the requested operative procedure. There nothing on examination to suggest that the proposed levels for surgery have any associated nerve root or

spinal cord compression. The symptoms are associated with nerve roots lower than the ones that would be exiting at those upper levels. The myelographic pictures of the cervical spine show the plates to be in normal position and “stable.” There is no indication that removal of those plates would be of any benefit regarding the patient’s symptoms. Of course removal of the plates could be indicated if fusion were pursued at the levels above because of interference with the fusion, but since this fusion is not thought indicated at the levels above, plate removal is not thought indicated.

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)