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Notice of Independent Review Decision

DATE OF REVIEW: 4/14/10

IRO CASE #:

Description of the Service or Services In Dispute
Percutaneous implantation of neurostimulator electrode array, epidural.

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, 3/2/10, 2/15/10, 2/11/10
xxxxxx notes 5/09- 1/18/10
Psychological evaluation 2/1/10, Dr.
Radiology report 5/7/09
MRI report lumbar spine 3/31/09
Operative reports medial branch blocks 2/23/09, Facet injections 10/12/09
ODG guidelines

PATIENT CLINICAL HISTORY (SUMMARY):

The patient is a female who in xx/xxxx when she slipped and fell, injuring her lower back. She felt pain in her low back and both lower extremities. Injections and physical therapy have not been helpful. Reports of her initial treatment have not been provided for this review. A lumbar 3/31/09 MRI showed a small left L5-S1 disk rupture, and severe degenerative disk disease changes at L4-5, but the remainder of the spaces were interpreted as normal. The patient's back pain is greater than her lower extremity pain. Her examination is unremarkable regarding nerve root compression, except for a sensory deficit questionably at L5 on the right side. Facet blocks and medial branch blocks have not been helpful

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 proposed spinal stimulator trial. The records provided for this review do not indicate that the patient's work up has been adequate to determine whether a more definitive operative procedure to get her closer to a more normal status can be

accomplished. Such a work up to explore pathology and instability should be completed prior to a spinal stimulator trial. In addition the patient does have some nerve root findings suggesting L5 nerve root trouble on the right side, and this could be shown on imaging studies as being surgically correctable. The patient should show that she is capable of weight loss before undergoing major operative procedures, and a spinal cord stimulator with possible permanent implantation is a major operative procedure.

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)