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IRO Certificate

Notice of Independent Review Decision

DATE OF REVIEW: 8/15/11

IRO CASE #:

Description of the Service or Services In Dispute
EMG/NCV lower extremities, Bilateral (MRI is not in dispute)

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

1. . denial of services on 6/10/11, 7/8/11.
2. Clinical notes by Dr., 2/9/11 - 7/21/11.
3. Disability determination report by Dr., 11/10/2010
4. Thoracic spine and lumbar spine x-ray reports of 4/21/2008 along with a lumbar CT myelogram on that same date.
5. Electrodiagnostic testing report on 4/11/2008 by Dr.
6. Official Disability Guidelines regarding electrodiagnostic studies.

PATIENT CLINICAL HISTORY [SUMMARY]:

This case involves a now male who in, fell and developed low back pain. He was told x-rays showed 2 compression fractures and subsequent x-rays have indicated the patient did sustain T12 and L4 compression fractures at that time His back pain continued and was soon joined by left lower extremity pain with weakness and tingling. Electrodiagnostic testing was carried out in April of 2008 and suggested possibly some left-sided L4-5 region trouble. Several epidural steroid injections were not helpful in dealing with his trouble. Pain consultation led to the trial for spinal cord stimulation, and a permanent implant was carried out on 5/5/2010. This became infected and had to be removed, despite the fact it was relieving his pain significantly. The patient pain has continued despite continued medications for pain, and anti-inflammatories. It is now been suggested that repeat MRI along with electrodiagnostic studies be done to try to find a reason for the patient's increasing difficulty with pain in his back and into his left lower extremity. His examination shows hyperactive reflexes and the motor examination is difficult because of pain and the sensory exam suggests changes in the left lower extremity which are a

“non-dermatomal.”

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

I agree with the denial of the proposed electrodiagnostic testing prior to obtaining a fresh MRI study, in view of the fact that if major changes of a surgical nature at the L4-5 level were present on the left side, then the electrodiagnostic testing would not be necessary to determine the level of radiculopathy. If the MRI does not show such changes then one would have to consider electrodiagnostic testing especially with nerve conduction studies since on the 4/11/2008 examination by Dr. there was some suggestion of the possibility of early neuropathy being present. For now, the electrodiagnostic testing 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)**