

Envoy Medical Systems, L.P.
1726 Cricket Hollow Dr.
Austin, TX 78758

PH: (512) 248-9020
FAX: (512) 491-5145
IRO Certificate #

Notice of Independent Review Decision

DATE OF REVIEW: 5/16/11

IRO CASE #:

Description of the Service or Services In Dispute

MRI Lumbar Spine w/ contrast

CT Lumbar Spine w/o contrast

X-Rays Lumbar Spine w/flex & extension views

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:

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

PATIENT CLINICAL HISTORY (SUMMARY):

This case involves a now male who developed back, and eventually, left lower extremity pain in association with lifting heavy boxes in xx/xxxx. Physical therapy, medications and rest were unsuccessful in dealing with his trouble. A lumbar MRI on 5/11/2010 showed L4-5 and L5-S1 changes compatible with nerve root compression especially severe on the left side. For this a 12/3/2010 lumbar laminectomy at L4-5 with laminectomy and fusion at L5-S1 without instrumentation was carried out. The patient showed initial improvement, but after three or four months his pain returned in his low back with some left groin pain. It had been recommended that MRI of the left groin region be obtained and a CT scan of his spine along with flexion and extension views of the lumbar spine.

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

I agree with the denial of the MRI and CT scans, but disagree with the request for flexion and extension views of the lumbar spine. In regard to my agreement, there is nothing in the records to indicate progressive neurologic difficulties, without anything on examination suggesting nerve root

compression. There is nothing that would suggest a finding that would be uniquely dealt with by the imaging testing and CT scan requested. There is nothing in their examination reports suggesting a reason for an MRI being necessary to evaluate the left groin pain.

Flexion and extension views of the lumbar spine might be helpful in determining instability being present, especially in view of the fusion that was carried out at the lower lumbar level. In addition, some changes may be seen that would suggest conservative management for a period of time, especially in view of the fact the patient is only about four months post operative at this time. Effective extension views could lead to such things as bracing, and a different approach surgically if that became necessary with failed conservative measures.

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)