

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

PH: (512) 248-9020
FAX: (512) 491-5145
IRO Certificate #4599

Notice of Independent Review Decision

DATE OF REVIEW: 10/17/11

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Lumbar discectomy/laminectomy, L4-L5-S1, Arthrodesis w/cages, Posterior instrumentation, Bone growth stimulator; LOS: 2 days.

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)
X Overturned (Disagree)
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. Services Corp.'s preauthorization reports, of 9/13/11 & 9/26/11.
2. Systems IRO report of 5/18/11.
3. Clinical notes by M.D., M.D., M.D. and M.D. from 2007 through 2011.
4. Lumbar spine x-ray reports of 9/8/11 and 8/23/11 with flexion and extension views.
5. EMG report of anal sphincter evaluation on 4/4/11 by M.D.
6. Urological evaluation report by M.D., 7/7/09 & 8/27/10.
7. Lumbar MRI report, 5/24/09.
8. ODG Guidelines

PATIENT CLINICAL HISTORY [SUMMARY]:

This case involves a female who in September, 2007 was intentionally struck on two occasions by a motor vehicle while she was at work. She sustained injuries to her left knee, the low back, and neck, with pain developing in all three of these areas. There has been subsequent development of fecal and urinary incontinence. Neurological evaluation has shown sphincter dysfunction secondary to spinal neurological problems supported by positive EMG. Treatment of her neck has resulted in a 50% improvement and consisted of surgery on 1/27/2010, with C4-5/C5-6 and C6-7 anterior cervical discectomy with fusion. Subsequent X-rays are showing stability in the cervical spine although there is some discomfort that continues intermittently. The patient's back and lower extremity pain persists along with bladder and bowel trouble, and an L4-5/L5-S1 decompression with fusion has been recommended along with the use of a bone growth stimulator.

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

I disagree with the denial of the proposed operative procedure. The patient's MRI, while showing no significant central or foraminal stenosis at any level, is still not incompatible with nerve

problems, especially in view of the instability that has been demonstrated on the flexion and extension views of the spine, and the problems the patient has on examination. Instability could still be continuing to contribute to nerve root difficulties, with the continuation of pain and bladder and bowel trouble. If this is a medically probable cause of the patient's continued trouble, then a stabilizing procedure with fusion in the lower two levels of the lumbar spine may be helpful in giving her some relief of her discomfort. Improvement in the bladder and bowel trouble would be

unusual considering the length of time that this is been present, but it could be significantly helped, by a change in the nerve status in her lower lumbar spine.

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)