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**Notice of Independent Review
Decision**

DATE OF REVIEW: 7/12/12

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

L5-S1 Posterior Lumbar fusion w/pedical screws and rods ICBG. Anterior Lumbar fusion, CCALIF, A01 screws. LOS: 3 days IP; CPT Code: 63048

**A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN
OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE
DECISION** Physician Board Certified in Neurological Surgery

**DESCRIPTION OF THE REVIEW OUTCOME THAT CLEARLY STATES WHETHER OR
NOT MEDICAL NECESSITY EXISTS FOR EACH OF THE HEALTHCARE SERVICES IN
DISPUTE.**

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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

PATIENT CLINICAL HISTORY (SUMMARY):

This case involves a now male, who, in xx/xxxx, bent over to pull on a bar and developed sudden low back pain soon joined by a bilateral lower extremity pain to the knees. Physical therapy has been limited and not helpful. The examination reveals straight leg raising to be only questionably positive there being low back pain produced only. There was no reflex, sensory, or motor deficit. An 8/30/11 clinical note by Dr. indicates flexion and extension views show no instability. An 11/15/11 EMG showed nothing in the way of evidence of radiculopathy.

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

I agree with the denial of the L5-S1 fusion. There is no evidence on EMG or examination of radiculopathy. On flexion and extension views there is no instability. In addition, the patient has had very limited physical therapy this being done in May and June for only six sessions. More in the way of therapy may be beneficial. The MRI abnormality at the L5-S1 level shows no surgical pathology without evidence of radiculopathy and instability in

association with the finding of a 1mm annular tear.

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)