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**Notice of Independent Review Decision**

DATE OF REVIEW: 8/04/14

IRO CASE NO.

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Inpatient hardware removal, L3-4 decompression, L2-3 transverse lumbar interbody fusion (TLIF) with three (3) days inpatient stay and purchase of bone growth stimulator and lumbar brace. Walker does not require prior authorization.

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION

Physician Board Certified Neurosurgery.

REVIEW OUTCOME

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

Upheld	(Agree) <input checked="" type="checkbox"/>
Overtured	(Disagree)
Partially Overtured	(Agree in part/Disagree in part)

PATIENT CLINICAL HISTORY SUMMARY

This case involves a now male who, in xx/xxxx, slipped on the floor, landing on his back and developing neck and lumbar spine pain. MRI's showed both disc trouble at the cervical and lumbar regions. In November of 1999 an anterior cervical diskectomy fusion was carried out at the C5-7 levels. On 11/08/04 cervical disc hardware removal was carried out and on 5/01/06 an anterior cervical diskectomy fusion was done at the L4-5 level. Lumbar procedures included an L5-S1 laminectomy, with fusion and diskectomy (8/30/01) and two lumbar epidural steroid injections in 2014. An MRI on 4/09/14 showed fusion changes at the L4-5 level with stenosis at the L3-4 level and possibly significant at the L2-3 level. An L3-4 laminectomy with hardware removal and fusion at the L3-4 level has been recommended.

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

**Opinion:** I agree with the denial for the requested surgical procedure. **Rationale:** There are no findings suggested by such things as flexion and extension x-rays of the lumbar spine that instability is present at the L3-4 level or elsewhere. The MRI suggested the possibility of instability more at the L2-3 level than at the proposed operative site. There are no findings such as positive straight leg raising, reflex, sensory, or motor deficits, or EMG results to suggest radiculopathy.

**DESCRIPTION AND SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION**

ACOEM-AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL  
MEDICINE UM KNOWLEDGE BASE

AHCPR-AGENCY FOR HEALTH CARE 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 & EXPERTISE IN ACCORDANCE WITH  
ACCEPTED MEDICAL STANDARDS X**

MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

MILLIMAN CARE GUIDELINES

**ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES X**

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 DESCRIPTION)

OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES  
(PROVIDE DESCRIPTION)