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**Notice of Independent Review Decision**

DATE OF REVIEW: 6/10/14

IRO CASE NO.

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

ALIF/PLF L4-5 with Tri Mod Back Brace; Outpatient, CPT: 22558 22851 22845 22612 63047 63048 22840 77003 63710

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

Physician Board Certified in Neurosurgery

REVIEW OUTCOME

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

<b>Upheld</b>	<b>(Agree) <u>X</u></b>
Overtured	(Disagree)
Partially Overtured	(Agree in part/Disagree in part)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

PATIENT CLINICAL HISTORY SUMMARY

This case is that of a male who sustained an injury in xx/xx/xx, developed pain in his back and right lower extremity. An MRI on 4/18/11 showed L4-5 changes with bulging, bi-laterally, into both foramina. On 9/27/11, an L4-5 right micro-discectomy was carried out with foraminotomy. There was some help for several months, but there was significant re-occurrence of pain in his low back which extended into both lower extremities as noted on 12/14/12. An MRI on 2/15/13 showed severe chronic changes at L4-5 with "diffuse bulging disc lateralizing asymetrically to the right". Also, there was L3-4 bulging lateralizing to the left. There was no record of flexion and extension views of the lumbar spine that were available. A 6/18/13 lumbar epidural steroid injection was not helpful.

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 L4-5 Anterior Lumbar Interbody Fusion and Posterior Lateral Fusion (ALIF/PLF) with Tri Mod Back Brace.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION (cont'd)

**Rationale**

There is no documentation of instability on flexion and extension X-rays or otherwise. There are changes at the L3-4 level which suggest the possibility of a reason for the left lower extremity pain to having

developed and this area would not be cared for by the proposed L4-5 operative procedure.

**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

AHCP-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)