Envoy Medical Systems, LP
4500 Cumbria Lane
Austin, TX 78727

PH: (512) 836-9040
FAX: (512) 491-5145
IRO Certificate #4599

Notice of Independent Review Decision

DATE OF REVIEW: December 03, 2012

IRO CASE NO.

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE
360 fusion L5-S1 w/bilateral laminectomy: 3 day LOS, CPT: 22558, 22612, 22840, 22845, 22851, 63047, 63048, 20930 x 2

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION
Physician Board Certified: **Neurosurgery.**

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

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)	

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Letters of Adverse Determination & Reconsideration, 11/01/12/ & 10/26/12
History/Physical, 10/12/12, 8/31/12, 4/13/12
Follow Up Notes: 10/10/12 - 5/14/12
MRI L-Spine, 3/07/12; CT L-Spine, 3/01/12
Operative Reports. 8/07/12, 6/26/12
ODG

PATIENT CLINICAL HISTORY SUMMARY

This case is that of a now female who has low back pain radiating down her left leg. The injury occurred in xx/xxxx. She developed pain in her back, but primarily in her left lower extremity. Examination revealed a positive straight leg raising on the left with a diminished left Achilles reflex and some sensory deficit in the L4-5 and S1 nerve distributions on the left. An MRI on 3/07/12 showed a left L5-S1 disk rupture which was probably extruded and extended laterally and, most likely, compromising the L5 and S1 nerve roots. Physical therapies, after the epidural steroid injections on two occasions, were not helpful. Diskectomy and fusion is recommended with fusion being thought necessary because the lateral disc excision will require "*the entire facet joint removal to decompress the foramen and L5 route*

adequately”.

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

Opinion/Rationale: I agree with the denial for the operative procedure. There are no findings suggestive of L5 -S1 instability, at this time, and lateral disc excision does not usually require the entire facet joint removal. The MRI report, indicating very little back pain, suggests a possible extruded fragment is present and removal of that fragment may possibly improve the problem. It is not thought that fragment removal will necessarily mean facet joint disruption to the extent that fusion is necessary. If that facet is disrupted, it would still not require fusion since there is no instability at the present time.

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)