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IRO Certificate #4599

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**NOTICE OF INDEPENDENT REVIEW DECISION**

**DATE OF REVIEW:** 820/07

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

Diagnostic interview, records review, case management, psychological testing 8/14/06

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

M.D. Board Certified in Anesthesiology and Pain Management

**REVIEW OUTCOME**

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

Upheld (Agree)

Overturned (Disagree)

Partially Overturned (Agree in part/Disagree in part)

Provide a 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**

Table of Disputed Services

Denial Letters

Letter to IRO 7/26/07

Medical Records 1/06 – 11/06, Dr.

Psychological valuation 8/16/06, Dr.

Medical records 3/06 – 8/06, Dr.

Medical records 2005, Dr. 2005

Medical records 2005, Dr.

Medical records, 2006 Dr.

Physical therapy records

EMG report 12/1/05

MRI report 10/19/05

X-ray report lumbar spine 9/12/05

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The patient is a female who has had low back and right hip pain since a fall. Diagnostic studies revealed multilevel small herniations, with probable right L4 irritation. Epidural steroids, TPI's, and SI joint injections were performed. The patient was treated with antidepressant medications.

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

I disagree with the benefit company's decision to deny the requested services. Per ODG tenth edition, Criteria for the general use of multidisciplinary pain management programs includes : an adequate and thorough evaluation has been made.

The patient was referred for a pain management program, and the evaluation performed was reasonable and medically necessary per ODG criteria.

This opinion does not diverge from ODG guidelines.

**A 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 JUDGMENT, 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)**