

Envoy Medical Systems, LP

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IRO Certificate #

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DATE OF REVIEW: 7/23/07

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Chronic Pain Management Program x 20 days

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:

XUpheld	(Agree)
Overtured	(Disagree)
Partially Overtured	(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 Letter – Corporation – 6/12/07; 7/6/07

Request and Reconsideration Letters for Treatment — 6/6/07; 6/29/07

MRI – Left Knee 12/28/05

Initial Consultation Notes MHR, LPC – 10/3/06

Behavioral Health Assessment – MA. LPC – 12/28/06; 5/29/07

Designated Medical Evaluation –M.D.- 11/7/06

Procedure Summary –M.D. 6/13/07

Clinical Notes –M.D. 9/6/06

Procedure Notes –M.D. 2/20/06 – 5/29/07

Impairment Rating Evaluation 4/27/07

Clinical Review: D.O.

Functional Capacity Evaluation –D.C. – 5/29/07; 12/7/07

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who lost his balance and then fell and injured his left knee in xx/xx/xx. After the failure of conservative care and injections, an arthroscopy was performed in June 2006. Post operative physical therapy, TENS, work hardening, and psychological treatments were performed

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

I agree with the benefit company's decision to deny the requested work hardening program. There is lack of evidenced in the records provided for this review to support need for chronic pain program. The patient has had physical therapy, TENS, work hardening, psychological treatment that are components of a multidisciplinary program. A chronic pain program is redundant and not medically necessary.

In addition, from ODG guidelines, 10th edition criteria 3 for a PMP states, – “The patient has a significant loss of ability to function resulting from chronic pain.” The patient in this case has been released to return to work with a 0% impairment rating. This criterion has not been met.

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)