

**Envoy Medical Systems, LP**  
1726 Cricket Hollow  
Austin, Texas 78758

PH. 512/248-9020

Fax 512/491-5145

**NOTICE OF INDEPENDENT REVIEW DECISION**

**DATE OF REVIEW:** 6/13/07

**IRO CASE #:**

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

20 Sessions Chronic Pain Management

**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:

X Upheld (Agree)

Overtaken (Disagree)

Partially Overtaken (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**

Denial letters

Office note 10/12/06, Dr.

Request and medical records 2007, Health Associates

Medical records 2007, Dr.

Medical records 2002 – 2007, Dr.

Medical Records 2004, Orthopedic & Occupational Rehabilitation

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The patient has had chronic low back pain since an L3-4 fusion. Anxiety and depression have been ongoing. Psychotherapy and medical management have been utilized. Vocational assistance and work hardening have also been provided.

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

I agree with the denial of the requested treatment. The patient has already had the major components of a multidisciplinary CPMP. Therefore, it would be redundant to undergo 20 sessions of a behavioral program.

ACOEM guidelines, 2004 Ch 5 & 6, stress the need for diagnostic clarity and individualized, time-limited treatment plans.

ODG Tenth edition states that it is important that “the patient exhibits motivation to change.” The records provided to not show that the patient is motivated. Similar treatment in the past has not been effective.

**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)**