Envoy Medical Systems, LP

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DATE OF REVIEW: 10/10/2007

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE
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)
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
Utilization Review Findings - Insurance Co. 8/15/07; 8/31/07; 9/11/07
Reconsideration Letter –Medical Centers –8/23/07
MRI Report – Right Ankle, 3/20/07
MRI Report – Left Knee, 3/20/07
MRI Report – Left Shoulder, 3/20/07
MRI Report – Cervical, 11/30/07
Ultrasound – Carotid Doppler
Operative Report – 2/15/07
Medical Reports –M.D. 7/17/07; 8/20/07
Medical Evaluation Report, M.D. 7/16/07
Medical Reports – D.O.12/13/07 – 5/21/07
Medical Reports –M.D., 10/11/06; 10/25/06
Orthopedic Consult Notes – M.D. 1/19/07
Medical Report –M.D.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who has had ongoing difficulties with pain involving the right shoulder, knee, neck, right ankle, and left knee. The patient was injured while working in a warehouse and racks of steel collapsed on top of him.
MRI of the shoulder March 2007 shows partial rotator cuff tear and biceps tenosynovitis.
MRI of the right knee shows a meniscus tear.

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 services. I concur with the ODG guidelines 10th edition. Criterion 1 requires that an adequate and thorough evaluation have been made. The evaluation in this case was cursory and did not utilize standard instruments, i.e. MMPI. Criteria 2 & 3 were met. Criterion 4 states that surgery is not warranted. It is unclear from the records whether surgery may be an option. Criterion 5 states that the patient exhibits motivation to change. In this case, patient motivation is not documented.

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**

X **MEDICAL JUDGMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**

☐ **MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**

☐ **MILLIMAN CARE GUIDELINES**

X **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)