

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

DATE OF REVIEW: 9/12/07

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

10 Sessions Chronic Pain Management Program – 5 days a week x 2 weeks

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:

- | | |
|---|----------------------------------|
| <input checked="" type="checkbox"/> Upheld | (Agree) |
| <input type="checkbox"/> Overturned | (Disagree) |
| <input type="checkbox"/> 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

Denial Letter: Insurance Co. June 8, 2007; July 9, 2007

MRI Reports – 6/2/06; 7/22/06

DDE Notes – M.D.; 3/27/07

Clinical Notes –M.D. 6/18/07

FCE Exam –Chiropractic Center

Clinical Notes –M.D. 7/18/07 –8/21/07

Mental Health Evaluation Addendum –PsyD; 5/27/07

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a xx-year-old female who complains of pain to her left knee, entire right arm especially elbow and wrist, to her neck going down her lower back and ribs with lifting, bending, walking and other work activities. Steroid injections were given. Surgery was performed in October 2006. Six sessions of psychotherapy have been provided.

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 – Ten sessions of a chronic pain management program. Per ODG guidelines, criteria 1 and 5 have not been met. There has not been a thorough battery of psychological testing. Based on the records provided, there have not been adequate evaluation of the patient's pathology to come to treatment conclusions. More importantly, there is no evidence that number 5 has been met. The patient does not exhibit motivation to change and forego secondary gains. One examiner on 3/27/07 identified significant symptom magnification.

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)