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IRO Certificate

Notice of Independent Review Decision

DATE OF REVIEW: AUGUST 4, 2008

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

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

Adverse Determination Letter – 6/18/08
Request letter 5/15/08
Appeal letter 6/4/08,
Follow up note 4/1/08, Dr.
Report 5/6/08, Evaluation 5/8/08,

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient has had low back pain since a xxxx lifting injury. Injections, chiropractic treatment, and physical therapy have been performed. Medications are prescribed.

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 chronic pain management program. The ODG guidelines relevant to this case are appropriate and the following have not been met.

1. There has not been a thorough psychological evaluation, other than an assessment that there are "no psychological stressors".
3. There is not a loss of ability to function independently. The patient is functioning independently.
5. No documented evidence was presented for this review that the patient exhibits motivation to change or is willing to forego disability.
6. The proposed treatment goals are vague and not patient specific.

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 JUDGEMENT, 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)**