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Notice of Independent Review Decision

MARCH 24, 2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

10 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 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"/> | Overtured | (Disagree) |
| <input type="checkbox"/> | 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
Determination Letters
ODG Guidelines
Requests and letters, 3/12/08, 1/18/08, 1/4/08, Dr.
Mental health Evaluation 12/13/07, D.

DDE reports 5/18/07, 1/28/08, Dr.

PATIENT CLINICAL HISTORY: SUMMARY OF EVENTS:

This case involves a xx year old female who in xx/xx sustained a chemical burn to the head, face and eye. She has anxiety, depression and chronic pain. She has been treated with psychotherapy, antidepressants and pain medications. She has had 20 sessions of a pain management program.

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 proposed 10 session chronic pain management program. The levels of pain and depression have not changed after 20 sessions of a pain management program. ACOEM guidelines stress the need for individualized, time limited treatment plan with clear functional goals, frequent assessment of the patients progress toward meeting the goals and modification of the treatment plan as appropriated based on the patient's progress. These guidelines have not yet 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 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)**