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**Notice of Independent Review Decision**

**DATE OF REVIEW:** 8/12/09

**IRO CASE #:**

Description of the Service or Services In Dispute  
Chronic pain management program 10 days

**A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION**

Physician Board certified in Anesthesiology and Pain Management

**REVIEW OUTCOME**

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

<b>X Upheld</b>	(Agree)
Overtured	(Disagree)
Partially Overtured	(Agree in part/Disagree in part)

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 letters, 7/13/09, 7/9/09, 2/24/09  
Letter medical Necessity 7/23/09, Request, 1/26/09, Dr. Dr.  
Carrier notes Jan. 2008 – July 2009  
Notes, 2009, Dr.  
Notes 2008, Dr.  
MRI right hip report 6/12/09, lumbar spine 2/11/08  
Spine evaluation report 1/13/09  
DDE 8/9/08, Dr.  
Arthrogram report 5/12/08, 4/7/08  
Operative reports 6/30/09, 11/14/08, 11/7/08, 2/29/08, 2/22/08, 12/13/07  
ODG guidelines

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The patient suffers chronic right hip pain. She also has low back pain and has undergone knee surgery. Currently she is being treated with mild analgesics, co-analgesics, and antidepressants. There is a diagnosis of trochanteric bursitis, and bursa injections have been recommended.

**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 chronic pain management program. I agree with the ODG guidelines in this case, and the ODG criteria have not been met. Specifically,

conservative measures have not been exhausted. Trochanteric injections have been proposed, but no record provided indicated that the patient received those injections. Further, the documentation provided did not indicate that the patient is willing to forgo benefits and is motivated to change.

**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**
- 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)**