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Notice of Independent Review Decision

DATE OF REVIEW: 12/10/09

IRO CASE #:

Description of the Service or Services In Dispute
10 sessions chronic pain management program

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:

Upheld	(Agree)
X Overturned	(Disagree)
Partially Overturned	(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, 11/17/09, 11/3/09
Peer reviews 11/16/09 Dr., 11/3/09 Dr.
Progress summary 10/27/09 Concurrent Report 10/10/09, Clinic Reports 12/2/09, 11/11/09, Preauth request 9/18/09 Dr.
Mental health Evaluation 9/17/09, Discharge Summary 9/17/09D.
Work Capacity evaluation report 9/22/09
ODG guidelines

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who has suffered back pain since a xx/xx injury. After the failure of conservative care, an L4-5 laminectomy was performed. The patient was treated with physical therapy and medications, and 20 days of a pain management program have been completed.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION.

I disagree with the decision to deny the requested additional 10 days of pain management program. I agree with the ODG that there should be a clear rationale for treatment duration in excess of 20 days, with reasonable goals to be achieved. After completing the 20-day program, the patient has achieved modest improvement. The note of 11/11/09 describes extenuating circumstances that justify an additional 10 sessions. Specific goals are described and relapse prevention training is included. Therefore, the ODG criteria have been met.

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)