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**Notice of Independent Review Decision**

March 9, 2009, amended form 3/12/09

**DATE OF REVIEW:** 3/9/09

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

Individual psychotherapy 1 x wk x 6 wks

**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)

Description of review outcome for each healthcare service in dispute

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

Adverse determination letters 2/10/09

Treatment Center documents 2/10/09,1/30/09, 1/9/09, 1/6/09, 12/10/08, 12/16/08

EMG report 1/14/09

Hospital record 9/17/08

Medical notes, Dr. 1/12/09, 11/12/08

ODG Guidelines

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The patient is a female who has had back and leg pain since a xx/xx injury. Physical therapy has been provided. EMG testing reveals bilateral high lumbar/thoracic radiculopathy. An MRI has not been performed.

**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 psychotherapy. ODG recommends an initial trial of 3-4 psychotherapy visits over two weeks, and additional visits if functional improvement occurs. It is not reasonable and necessary to request six visits. In addition, prior to therapy, and in order to establish a treatment plan, additional studies such as MRI are necessary to clarify the patient's diagnosis.

**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
- 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)