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IRO Certificate #

**DATE OF REVIEW: 5/28/09**

**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:

**X Upheld** (Agree)  
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, 5/5/09, 4/17/09  
Request for Medical Dispute Resolution 5/19/09, Dr.  
Request for services 4/9/09, Dr.  
Patient reevaluation 4/3/09, Dr.  
PPE 4/7/09  
Peer review 3/20/09, Dr.  
Report myelogram thoracic spine, 10/15/08  
Report 4/9/08, Dr.  
Neurological evaluation 1/21/08, Dr.  
MRI reports cervical spine 12/14/07, thoracic spine 11/14/07

ODG Guidelines

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The patient continues with pain in his mid and low back since a xx-xx-xx injury. Previously he had a lumbar laminectomy. He has had multiple interventions, including physical therapy, injections, work conditioning and psychotherapy.

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

A Physical Performance Evaluation revealed that the patient is capable of performing at the heavy physical demand level. Therefore, ODG criterion No. 3 – loss of ability to function independently – is not met.

The patient has already been treated with psychotherapy, and the record does not show that whatever perceived psychological issues remain would likely change with further psychotherapy, and ODG criteria No. 6 –negative predictors of success have been addressed – has not 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
- 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)