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**Notice of Independent Review Decision**

**DATE OF REVIEW:** 4/2/10

**IRO CASE #:**

Description of the Service or Services In Dispute  
Chronic pain management program, 10 additional 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:

X Upheld	(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, 3/9/10, 2/8/10, 2/2/10, 10/29/09  
Reconsideration request 3/2/10, Request 2/2/10, Notes, Dr. 2/2/10  
H & P 10/24/09, Dr.  
Notes 1/15/09, Dr.  
Injury 1 Treatment Center records 11/12/08 –  
MRI cervical spine report 11/6/08  
PPE report 1/28/10  
FCE report 10/16/09  
North Dallas Advanced Diagnostics report 10/30/08  
ODG guidelines

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The patient sustained multiple injuries in a xx/xxx motor vehicle accident. He has been treated with physical therapy, work hardening, 18 sessions of psychotherapy, and 20 days of a pain management program. There have been minimal gains.

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

I agree with the decision to deny the requested additional days of chronic pain management program. The patient has undergone extensive behavioral interventions, including work hardening, psychological counseling and 20 days of a pain management program. I agree with the ODG criteria, which stipulate that there should be documentation of progress made and an individualized program with specific goals and reasons for those goals. This patient has had

modest success to date with extensive intervention. It is not reasonable and necessary to continue a program that has achieved only modest gains.

**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)