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*Notice of Independent Review Decision*

**DATE OF REVIEW: 5/28/10**

**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:

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 5/5/10, 4/21/10, 3/2/10  
IRO summary 5/17/10  
Request for authorization 4/15/10; Request for reconsideration 4/27/10  
Chronic Pain management program status report for program not begun\  
Clinical notes, Dr. 2010  
Initial clinical evaluation 2/18/10, Interview 2/24/10, Behavioral Health  
Medical supplyprescriptions  
Chiropractic notes 2008, 2009, Chiropractic  
Clinical evaluation report 4/14/10, 2/24/10  
Report, Dr. 3/15/10  
Work status reports  
Diagnostic testing reports, 4/1/10, 3/24/10, 3/20/09, 11/12/08  
Therapy notes 2010  
Report, Dr. 10/29/09  
Amended IME 3/23/09, Dr.  
ODG guidelines

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The patient is a female who suffered a back injury in xx/xx. Physical therapy, work conditioning, medications, individual psychotherapy have been provided.

**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 chronic pain management program. The additional documentation provided by behavioral Health fulfills all of the criteria for 10 days of pain management program.

**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)