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Notice of Independent Review Decision

DATE OF REVIEW: 5/4/10

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

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 review outcome for each healthcare service in dispute

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Adverse determination letters, 4/14/10, 3/26/10, 3/5/10
Request for reconsideration 3/15/10
Carrier Case Summary report 3/12/10
Clinical notes, 10/22/09, 11/12/09, 12/10/09, Dr.
Physical therapy notes and testing 2010
Mental health Evaluation 2/9/10
MRI right knee report 11/16/09
ODG guidelines

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient sustained a right patella fracture that was treated surgically. Pain persists. The patient has undergone brief physical therapy. The patient suffers from preexisting depression and is taking Zoloft.

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

I agree with the denial of the proposed pain management program. I agree with the ODG that there should be no other treatment option prior to initiating a chronic pain management program. The patient has had only four sessions of physical therapy, and has not tried work hardening or psychotherapy. Other options should be explored prior to embarking on a behavioral pain management program.

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)