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Notice of Independent Review Decision

DATE OF REVIEW: 9/21/10

IRO CASE #:

Description of the Service or Services In Dispute
Chronic Pain Management 10 sessions x 8 hours

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:

- | | |
|---|----------------------------------|
| <input checked="" type="checkbox"/> Upheld | (Agree) |
| <input type="checkbox"/> Overturned | (Disagree) |
| <input type="checkbox"/> 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, 8/17/10, 7/16/10
Appeal letter 8/30/10, Request for reconsideration 8/11/10, 8/16/10, Request 7/13/10
Notes, Dr. 2010
Notes, Dr. 2010
Notes, Direct Medical Healthcare 2009, Mental Health Evaluation 6/14/10,
treatment plan 6/14/10
Toxicology report 8/19/10, 7/7/10
Pharmacy report 8/19/10
FCE report 6/28/10
Radiology report 3/17/09
MRI report 12/18/08
Operative report 7/24/09
ODG guidelines

PATIENT CLINICAL HISTORY (SUMMARY):

The patient is a male who sustained a closed head injury and cervical injury on xx/xx/xx; which resulted in a craniotomy, cervical fusion, and a right orbital reconstruction. Multiple medications have been prescribed, including potent opiates.

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 pain management program. Pharmacy records indicate a prescription for hydrocodone was given by Dr. on 6/15/2010. Pharmacy records confirm that the medicine was dispensed. A urine drug screen on 7/1/2010 showed no opiates. There is a question of diversion or lack of compliance or abuse. Therefore, ODG requirements for a Chronic Pain

Management Program are not met, and it is not reasonable and necessary for the patient to participate in the requested 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)