

Envoy Medical Systems, L.P.
1726 Cricket Hollow Dr.
Austin, TX 78758

PH: (512) 248-9020
FAX: (512) 491-5145
IRO Certificate #4599

Notice of Independent Review Decision

DATE OF REVIEW 6/28/11

IRO CASE #:

Description of the Service or Services In Dispute
Chronic Pain management Program 10 sessions

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, 6/2/11, 3/31/11, 6/1/11, 5/19/11
Request for reconsideration 5/27/11, Updated request for services 5/10/11,
FCE report 2/17/11
ODG guidelines

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who was injured in xx/xxxx when he fell, resulting in back and shoulder pain. Apparently surgery was performed in October 2008, but the records provided for this review do not indicate the type of surgery. Psychotherapy has been completed. Anxiety and depression are present.

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 Chronic Pain Management Program. Anxiety and Depression are documented, but documentation of prior treatment has not been provided for this review. No documentation was provided of injection therapy or type of surgery. There is lack of documentation that lower levels of care have been utilized and exhausted. There is mention of Klonopin and Paxil, but the dose is not specified. There is no mention of other medications such as non-opiate analgesics. Due to the lack of documentation of exhaustion of other treatment modalities, the ODG are not 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)