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IRO Certificate #4599

Notice of Independent Review Decision

DATE OF REVIEW: 5/12/11

IRO CASE #:

Description of the Service or Services In Dispute
6 sessions of individual psychotherapy

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION

Physician Board Certified in Physical Medicine and Rehabilitation

REVIEW OUTCOME

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

Upheld	(Agree)
<input checked="" type="checkbox"/> 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, 4/6/XX, 3/15/XX
Summary 4/25/XX
Clinic reports from Clinic1/20XX-4/20XX
Clinical notes from Dr 4/20XX
Worker's Compensation Request for Medical Care form 10/21/XX Job Offer 10/22/XX
Medical records 2/20XX from Dr.
Medical records 11/20XX from Clinic
Medical Records from Hospital XX/20XX

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a XX-year-old female who sustained an injury to the lumbar spine in XX/XXXX. She was lifting a heavy box, felt pain in her low back, and was taken to the ER. MRI in 12/20XX revealed some disk protrusions and bulge findings. The patient underwent physical therapy and some work hardening. On 2/24/XX, the patient had an initial behavioral medicine consultation. The patient only speaks Spanish.

Analysis and Explanation of the DECISION INCLUDE clinical basis, Findings and Conclusions Used to Support the Decision.

I disagree with the benefit company's decision to deny the requested services. The review indicates that the patient has a need for psychological treatment. The ODG pain chapter concerning psychological treatment states that cognitive behavioral therapy and self-regulating treatments are recommended for appropriately identified patients, and that psychological

treatment incorporated into pain treatment has been shown to have positive effects on return to work.

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)**