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Notice of Independent Review Decision

DATE OF REVIEW 2/14/12

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Individual Psychotherapy 1x wk x 4wks; Biofeedback Therapy 1x wk x 4wks

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

Physician Board Certified in Pain Management and Anesthesiology.

REVIEW OUTCOME

Upon independent review the reviewer finds that the previous adverse determination 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, 1/02/12, 12/21/11
Adverse Determination Letter, Claims Mgmt, 4/19/10
Adverse Determination Letter, M.D., 3/05/10
Clinical Notes, M.D., 1/06/12, 12/19/11
Clinical Notes, from URA, 12/20/11 - 11/18/09
Diagnostic & Lab Notes, Operative, various, 5/13/11 – 11/18/09
ODG Guidelines

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a female who sustained a work related injury in xx/xx while employed as an. She reported she was struck by a case of falling Gatorade, claiming she was struck in the face and shoulder area. After failure of conservative therapy, patient had a 2 level anterior cervical discectomy and fusion, C4-5, C5-6 with bone grafts x2. ESI performed pre and post-op. She developed low back and left shoulder pain. A psychological evaluation was performed on 6/16/10. An electromyogram on 3/16/11 showed left C6 radiculopathy. There is pseudoarthrosis at C5-6. Psychotherapy, 6 sessions, has been provided with no improvement.

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

Per the ODG there has been minimal functional improvement after six (6) sessions. The underlying pain source (non-union C5-6) has yet to be addressed. ODG not met for additional psychotherapy. ODG do not endorse biofeedback for neck/shoulder issues.

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)**