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IRO Certificate #4599

Notice of Independent Review Decision

DATE OF REVIEW 2/23/12

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

97799 Chronic Pain Management Program 5 x wk x 2wks

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 w/backup, 1/18/12, 12/19/11
Summary, 2/07/12
Clinical Notes, 1/06/12 - 6/28/11
Clinical Notes, 11/15/11
Diagnostic Radiology & Lab notes, 1/11/12 - 8/18/08
Compilation of medical records, 2004 onward.
ODG Guidelines

PATIENT CLINICAL HISTORY [SUMMARY]:

This patient, a gentleman, sustained a back injury on xx/xx/xx, resulting in low back pain of 7 years duration. Physical therapy, work hardening medications, and injections have been performed. MRI shows disc bulges, and physical exam is compatible with the facets as a pain generator. He has had injections, but there is no indication that he had facet protocol performed.

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

I agree with the company to deny the request. The ODG rationale stipulate that all other

options have been explored. There is no indication that this has been done, rather, there is evidence on physical exam, that the facets are a pain generator. There is no documentation that facet radio frequency protocol has been performed. ODG are not met for the requested 80 hours of a chronic pain management program.

The only injection therapy documented were trigger point injections. There was mention of referral records for the injured worker by a however, there were no records from his office.

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)**