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IRO Certificate #4599

Notice of Independent Review Decision

DATE OF REVIEW: 8/30/13

IRO CASE NO.

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE *
80 hours of chronic pain management.

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

Physician Board Certified in Pain Management & Anesthesiology

REVIEW OUTCOME

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

Upheld (Agree)

Overtured (Disagree) X

Partially Overtured (Agree in part/Disagree in part)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Utilization Review Determination Letters (2), 7/16/13, 6/06/13

Letter of Reconsideration, 7/16/13

Reply Letter, 7/23/13; Appeal Result, 6/17/13

Pre-Auth (request for active rehab/80 hrs), Treating physician, 5/30/13; Extremity Evaluation, 5/22/13

Physical Performance Evaluation/Treatment Plan, 4/24/13

Progress Notes: progress summary, 6/24/13

Designated Doctor Evaluation, 7/27/13

ODG (Official Disability Guidelines)

PATIENT CLINICAL HISTORY SUMMARY

The individual has had 10 sessions of physical therapy, 6 individual psychological treatment sessions and medications have been utilized. He underwent lumbar surgery on 4/13/05. A psychological evaluation reveals depression and anxiety.

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

Decision: I disagree with the benefit company's decision to deny the requested 80 hours of Chronic Pain Management Program.

Rationale: ODG criteria for this modality have been met. The Appeal addresses each circumstance outlined by ODG that are required for a Pain Management Program. Each of these circumstances are met. There is significant loss of function, dependence on health care providers, need for assistance from family members, physical de-conditioning, withdrawing from social activities, failure to meet physical demand requirement, depression and anxiety, fears of functioning. Previous methods of treating the pain have been unsuccessful. There are no additional treatment procedures deemed adequate. Multi-disciplinary evaluation has been made. ODG are met for the requested procedure.

DESCRIPTION AND SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION

ACOEM-AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL
MEDICINE UM KNOWLEDGE BASE

AHCPR-AGENCY FOR HEALTH CARE 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 & EXPERTISE IN ACCORDANCE WITH
ACCEPTED MEDICAL STANDARDS X**

MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

MILLIMAN CARE GUIDELINES

ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES X

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 DESCRIPTION)

OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES
(PROVIDE DESCRIPTION)