Envoy Medical Systems, LP
4500 Cumbria Lane
Austin, TX 78727

PH: (512) 705-4647
FAX: (512) 491-5145
IRO Certificate #XX

DATE OF REVIEW: 08/06/18

IRO CASE NO.XXXX

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE
XX 2.5 mg
XX, #30 Qty

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION
Physician Board Certified in Anesthesiology & Pain Management

REVIEW OUTCOME

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

Upheld	**(Agree) X**
Overturned	(Disagree)
Partially Overturned	(Agree in part/Disagree in part)

PATIENT CLINICAL HISTORY SUMMARY
This XX sustained a work related injury in XX, when XX fell XX. A low back injury resulted. XX has had physical therapy, had a period of no treatment, and on XX XX noted pain in the coccyx. The pain was rated at a 9 to 10, out of 10; with 7 of 10 at its best and 10 of 10 at its worst. The individual has multiple medical problems. Medications include XX, XX, XX, XX, and XX, 10 mg, 1 tablet every 6 hours, as needed. A coccyxgeal nerve block was performed on XX the results of which were not available for review.

Dr. XX reviewed the records on XX. XX denied the request stating that the clinical report noted no pain and only subjective findings of pain to palpation over the coccyx. The claimant had not recently tried or failed prescription medications.XX is not supported by current evidence based guidelines for the treatment of chronic pain.

Dr. XX performed the appeal review XX. Both reviewers stated that peer review guidelines do not support the use of XX for pain control.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION
Opinion: I agree with the benefit company's decision to deny the requested service.

Rationale: Peer review guidelines do not endorse the use of XX. XX is approved only for chemotherapy nausea and XX weight loss. There was one study noted in the Official Disability Guidelines (ODG) where XX with a dose of 10-20 mg produced an analgesic effect. The dosage requested, however, in this case is 2.5 mg. There is insufficient data to support the use of XX for chronic pain. The requested service is not a medical necessity.

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)