Envoy Medical Systems, LP

1726 Cricket Hollow
Austin, Texas 78758
Fax 512/491-5145

IRO Certificate #4599

NOTICE OF INDEPENDENT REVIEW DECISION

December 31, 2004

Re: IRO Case # M2-05-0468

Texas Worker's Compensation Commission:

Envoy Medical Systems, LP (Envoy) has been certified as an independent review organization (IRO) and has been authorized to perform independent reviews of medical necessity for the Texas Worker's Compensation Commission (TWCC). Texas HB. 2600, Rule133.308 effective January 1, 2002, allows a claimant or provider who has received an adverse medical necessity determination from a carrier's internal process, to request an independent review by an IRO.

In accordance with the requirement that TWCC assign cases to certified IROs, TWCC assigned this case to Envoy for an independent review. Envoy has performed an independent review of the proposed care to determine if the adverse determination was appropriate. For that purpose, Envoy received relevant medical records, any documents obtained from parties in making the adverse determination, and any other documents and/or written information submitted in support of the appeal.

The case was reviewed by a physician who is Board Certified in Anesthesiology and Pain Management, and who has met the requirements for the TWCC Approved Doctor List or who has been granted an exception from the ADL. He or she has signed a certification statement attesting that no known conflicts of interest exist between him or her and any of the treating physicians or providers, or any of the physicians or providers who reviewed the case for a determination prior to referral to Envoy for independent review. In addition, the certification statement further attests that the review was performed without bias for or against the carrier, medical provider, or any other party to this case.

The determination of the Envoy reviewer who reviewed this case, based on the medical records provided, is as follows:

<u>Medical Information Reviewed</u>

1. Table of disputed services
2. Denial letters
3. Prescriptions for stimulator
4. Letters from prescribing M.D.
5. Patient usage reports
6. D.C. reports and notes
7. Orthopedic surgeon report 6/17/02

8. TWCC 69 and DDE report 6/19/02
9. Procedure report 10/14/04
10. MRI report 8/30/04
11. D.O. reports and notes
12. Operative report 6/23/04

History
The patient is a 35-year-old female who injured her lower back in ___. The patient has undergone a lumbar diskectomy and extensive rehabilitation, but back and left knee pain have persisted. There is evidence in the records provided for this review that psychological issues are contributing to her continued pain complaints.

Requested Service(s)
Purchase RS4i sequential stimulator

Decision
I agree with the carrier's decision to deny the requested purchase.

Rationale
The records provided for this review do not adequately document that the patient's use of the RS4 has been beneficial to her. Her pain is at least no better with RS4 therapy, and recent D.C. and M.D. evaluations indicate that the patient is worsening.

This medical necessity decision by an Independent Review Organization is deemed to be a Commission decision and order.

YOUR RIGHT TO REQUEST A HEARING

Either party to medical dispute may disagree with all or part of the decision and has a right to request a hearing.

If disputing a spinal surgery prospective decision, a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **10** (ten) calendar days of your receipt of this decision (28 Tex. Admin. Code 142.5(c)).

If disputing other prospective medical necessity (preauthorization) decisions, a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **20** (twenty) calendar days of your receipt of this decision (28 Tex. Admin. Code 142.5(c)).

This decision is deemed received by you 5 (five) days after it was mailed or the date of fax (28 Tex. Admin. Code 102.5(d)). A request for a hearing and a **copy of this decision** must be sent to:

Chief Clerk of Proceedings / Appeals Clerk
P.O. Box 17787
Austin, Texas 78744

Fax: 512-804-4011

The party appealing this decision shall deliver a copy of its written request for a hearing to other party involved in this dispute.

Sincerely,

_____

In accordance with Commission Rule 102.4 (b), I hereby certify that a copy of this Independent Review Organization (IRO) decision was sent to the carrier and the requestor or claimant via facsimile or US Postal Service from the office of the IRO on this 31st day of December 2004.

Signature of IRO Representative:

Printed Name of IRO Representative: