Envoy Medical Systems, LP

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

IRO Certificate #4599

NOTICE OF INDEPENDENT REVIEW DECISION

February 4, 2005

Re: IRO Case # M2-05-0646

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:

Medical Information Reviewed

1. Table of disputed services
2. Denial letters
3. TWCC 69 11/16/04
4. IR evaluation 11/16/04

5. Medical consultation reports 11/10/04, 11/1/04 Dr. Keene
6. Reevaluation, 10/29/04 Dr. Miller
7. CT lumbar myelogram 8/25/04
8. Lumbar spine series 8/25/04
9. ESI operative report 7/23/04
10. MRI report 9/23/03

History
The patient is a 39-year-old male who has had lower back pain since a ___ fall. The records provided for this review indicate that the patient has been treated with extensive, even excessive physical therapy, work hardening and epidural steroid injections. A CT myelogram shows a protrusion at L4-5 with canal narrowing. Back surgery has been offered, but declined by the patient.

Requested Service(s)
Chronic pain management program

Decision
I agree with the carrier's decision to deny the requested pain management program.

Rationale
Extensive physical therapy has been performed. The records indicated that there is some depression. The depression can be treated with oral antidepressants. A pain management program is not reasonable and necessary, when simple measures can still be utilized.

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,

_____

Daniel Y. Chin, for GP

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 7th day of February 2005.

Signature of IRO Representative:

Printed Name of IRO Representative: Alice McCutcheon

Requestor: Dr. C. Janine Miller, Attn Adriana Valdez, Fx 214-902-0104

Respondent: Texas mutual ins. Attn Ron Nesbitt, Fx 404-3980

Texas Workers Compensation Commission Fx 804-4871 Attn: