

**Envoy Medical Systems, LP**  
**1726 Cricket Hollow**  
**Austin, Texas 78758**  
Fax 512/491-5145

**IRO Certificate #4599**

**NOTICE OF INDEPENDENT REVIEW DECISION**

February 28, 2005

**Re: IRO Case # M2-05-0656**

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, Rule 133.308 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. Psychological evaluation report 5/20/04 Dr. Ziegler
4. Request for appeal 11/4/04 Dr. Caruso
5. PPE 10/18/04
6. Physical therapy records 2003, 2004

7. Operative reports 1/29/04, 1/6/05 Dr. Mann
8. Orthopedic surgeon notes and reports 2003, 2004

History

The patient is a 34-year-old male who injured his right knee in \_\_\_\_\_. The patient underwent right knee surgery on 1/6/05, and physical therapy and rehabilitation was planned. The patient has undergone work hardening. A psychological evaluation revealed depression

Requested Service(s)

Chronic pain management program x 30 days

Decision

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

Rationale

The patient recently underwent surgery. It is anticipated that after physical therapy and rehabilitation his status will be improved. It is not reasonable and necessary to embark on a behavioral program at this time. Oral antidepressants should be utilized to address the depression.

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,

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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 28<sup>th</sup> day of February 2005.

Signature of IRO Representative:

Printed Name of IRO Representative: Alice McCutcheon

Requestor: Positive Pain management, Attn Helena Fx 972-487-1916

Respondent: Specialty Risk Services, Attn Elise La Pierre, Fx 877-538-2248

Texas Workers Compensation Commission Fx 804-4871 Attn: