

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

IRO Certificate #4599

NOTICE OF INDEPENDENT REVIEW DECISION

May 10, 2005

Re: IRO Case # M2-05-1084 –01

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. Request for Reconsideration, 1/25/05, 2/21/05 S. Persinger,
4. Peer Review, 6/9/03, Dr. Renshaw

5. Notes, Dr. Lenderman
6. Patient information 12/7/04, Bexar County Healthcare Systems
7. Evaluation 11/30/04, S. Persinger

History

The patient is a 50-year-old female who has had chronic back pain since a ___ injury. The patient also suffers from severe depression. Prior to lumbar surgery in 2002, the patient was treated with physical therapy, medications, injections, shoulder surgery, and a pain management program. An L5-S1 fusion was performed in 2002.

Requested Service(s)

10 days chronic pain management program

Decision

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

Rationale

Treatment of patients should be cost effective. Cost effective management begins with antidepressant medications. There should be an aggressive trial of SSRI antidepressants (or their equivalent) prior to considering a behavioral pain management program. It is noted that the patient is taking only Amytriptyline for depression/anxiety, and no details related to this are in the records provided for this review.

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 11th day of May 2005.

Signature of IRO Representative:

Printed Name of IRO Representative: Alice McCutcheon

Requestor: Bexar County Healthcare Systems, Attn Nick Kempisty

Respondent: City of San Antonio, Attn Wisteria Hutchenson, Fx 346-2539

Texas Workers Compensation Commission Fx 804-4871 Attn: