

Envoy Medical Systems, LP
1726 Cricket Hollow
Austin, Texas 78758

PH. 512/248-9020
IRO Certificate #4599

Fax 512/491-5145

NOTICE OF INDEPENDENT REVIEW DECISION

August 26, 2005

Re: IRO Case # M2-05-2093-01

Texas Worker's Compensation Commission:

Envoy Medical Systems, LP (Envoy) has been certified as an independent review organization (IRO) by the Texas Department of Insurance and has been authorized to perform independent reviews of medical necessity for the Texas Worker's Compensation cases. 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 Worker's compensation assign cases to certified IROs, this case was assigned 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 Worker's Compensation 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. Evaluation 9/18/02, Dr. Hostetter

4. Report 1/19/02, Dr. Simon
5. Reviews 3/20/05, 2/10/05 Dr. Pearlman
6. Records from Positive Pain Management 2004-2005
7. Records, Dr. Belvis
8. Initial history and physical 12/30/02, Dr. Hernandez
9. Report MRI of the lumbar spine 11/6/02
10. Records, San Antonio Orthopedic Group
11. Records from Southwest Texas Pain Clinic
12. NCS/EMG report 10/30/03

History

The patient has had left shoulder pain since a ___ injury. Numerous injection procedures have not been helpful. There is significant psychological dysfunction that has required multiple inpatient psychiatric treatments. Numerous opiate and psychotropic drugs have been prescribed.

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

The psychological aspects of this patient's pain complaints are predominant. These issues have been addressed by inpatient and outpatient psychotherapy. Based on the records provided for this review, there is little likelihood that additional therapy will be of significant benefit. Therefore, it is not cost effective or reasonable and necessary to continue a behavioral pain management program

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 26th day of August 2005.

Signature of IRO Representative:

Printed Name of IRO Representative: Alice McCutcheon

Requestor: Positive Pain Management, Attn Heidi Wilson, Fx 972-487-1916

Respondent: Ins. Co. of North America, Attn Javier Gonzalez, Fx 394-1412

Texas Workers Compensation Commission Fx 804-4871 Attn: