Envoy Medical Systems, LP
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IRO Certificate #4599

NOTICE OF INDEPENDENT REVIEW DECISION

October 4, 2005

Re: IRO Case # M2-05-2210–01

Texas Worker's Compensation Division:

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 Workers' 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 Workers' 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 Workers' 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:

<u>Medical Information Reviewed</u>

1. Table of disputed services
2. Denial letters

3. Physical therapy / work hardening notes
4. Evaluation report 4/25/00, Dr. Ullman
5. Gulf Coast Chiropractic notes
6. Notes, Dr. Leal
7. Operative report 12/15/03, Dr. McConnell
8. Houston Center for Pain Management notes
9. Initial interview 6/2/05, Addendum 6/27/05 J. Flowers
10. Request for reconsideration 7/6/05, Dr. Jackson
11. Gulf Coast Orthopedic & Spine Associates records
12. Texas Orthopedic and Injury records, Dr. Jennings

History
The patient is a 44-year-old female who was injured in ___ and developed back pain. Surgery was performed, including fusion, but the patient's pain has persisted. Work hardening, physical therapy, chiropractic care and behavioral treatment have been performed. There is evidence of psychological overlay contributing to her continued pain complaints.

Requested Service(s)
Chronic pain management 5 x wk x 6 wks

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

Rationale
The patient has had the benefit of extensive treatment, including physical and behavioral therapy, and medications without significant success. It would not be reasonable and necessary to continue behavioral therapy when based on the records provided for review, there is little chance of improvement.

This medical necessity decision by an Independent Review Organization is deemed to be a Worker's Compensation decision and order.

YOUR RIGHT TO APPEAL

If you are unhappy with all or part of this decision, you have a right to appeal the decision. The decision of the Independent Review organization is binding during the appeal process.

If you are disputing a decision other than a spinal surgery prospective decision, the appeal must be made directly to the district clerk in Travis County (see Texas Labor Code sec. 413.031). An appeal to District Court must be filed not later than 30 days after the date on which the decision that is the subject of the appeal is final and appealable. If you are disputing a spinal surgery prospective decision, a request for a hearing must be in writing and it must be received by the Division of Workers' Compensation, Chief Clerk of Proceedings, within ten (10) days of your receipt of this decision.

_____
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 4th day of October 2005.

Signature of IRO Representative:

Printed Name of IRO Representative: Alice McCutcheon

Requestor: Dr. Jackson, Attn Courtney, Fx 713-527-8558

Respondent: Texas Mutual ins., Attn Latreace Giles, Fx 224-7094

Texas Workers Compensation Division, Fx 804-4871 Attn: