

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

November 9, 2005

Re: IRO Case # M2-06-0046-01 ____

Texas Department of Insurance, Division of Workers' Compensation:

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 Division of Workers' Compensation cases. 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 the Division of 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 Division of 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 the injured employee, the injured employee's employer, the injured employee's insurance carrier, the utilization review agent, 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 and DDE 5/10/05, Dr. Erredge
4. Clinical / S.O.A.P. notes 2005, Dr. Sealy-Wirt
5. Requestors position regarding pre-authorization 8/3/05, Dr. Vuong
6. MRI left ankle reports 12/14/04, 7/22/04
7. Electrodiagnostic studies report 8/4/04
8. Reports 2005, Dr. Dutra
9. Notes 1/4/05, Dr. Cheleuitte
10. Request for initial trial of 10 days chronic pain management program 7/11/05, P. Bohart
11. Reconsideration request 8/3/05, P. Bohart
12. Pain rehabilitation program design, Buena Vista Workskills
13. Initial psychosocial interview 8/19/04,
14. Physical performance evaluation 6/20/04
15. Case conference note 2/15/05, C. Ramirez
16. Multidisciplinary work hardening plan & goals 4/29/05, Dr. Coverstone
17. Presurgical diagnostic interviews 1/3/05, 6/2/04 E. Keller, P. Bohart
18. TWCC work status reports
19. ERGOZ evaluation summary reports
20. Initial consultation note 7/21/04, Dr. S.Ali Mohamed

History

The patient is a 29-year-old male who has had left foot pain since he fell down stairs and suffered a sprain injury in _____. The patient has an impairment rating of 0%, and returned to work after the injury, but later stopped working. He has been treated with massage therapy, physical therapy, TENS unit and ultrasound and a work hardening program, but pain persists. There is depression present. A 10/5/05 S.O.A.P. note indicates that the patient will be referred for surgical consultation.

Requested Service(s)

Chronic pain management 10 sessions.

Decision

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

Rationale

The patient has already been treated with components of the pain management program without benefit. This is a predictor of poor response to additional therapy. Also, he is taking small doses of antidepressants. Care should be provided in a cost effective manner. Therefore, aggressive antidepressant therapy should be utilized prior to considering a pain management program.

This medical necessity decision by an Independent Review Organization is deemed to be a Division of Workers' 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 9th day of November 2005.

Signature of IRO Representative:

Printed Name of IRO Representative: Alice McCutcheon

Requestor: Buena Vista Workskills, Attn James Odom, Fx 214-692-6670

Respondent: Texas mutual Ins., Attn Latreace Giles, Fx 224-7094

Texas Department of Insurance, Division of Workers' Compensation: Fx 804-4871 Attn: