

Envoy Medical Systems, LP
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IRO Certificate #4599

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NOTICE OF INDEPENDENT REVIEW DECISION

February 9, 2006

Re: IRO Case # M2-06-0289 -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. Records, Bexar County Healthcare Systems

4. Report 8/11/05, Dr. Zarzuela

History

The patient is a 64-year-old female who has had back pain since a ___ injury. Fusion was carried out in 1992 at L4-5. Numerous diagnostic and therapeutic measures have been performed, including physical therapy, injections, work conditioning, counseling, and a multi-disciplinary pain management program.

Requested Service(s)

Chronic pain mgmt x 10 sessions.

Decision

I agree with the decision to deny the requested chronic pain management.

Rationale

A behavioral pain management program was reasonable for this patient. The patient participated in such a program, however, with no lasting improvement. That program included the modalities currently requested. It is not reasonable and necessary to repeat the same modalities that have not provided relief in the past.

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 10th day of February 2006.

Signature of IRO Representative:

Printed Name of IRO Representative: Alice McCutcheon

Requestor: Bexar County Healthcare Systems, Attn Nick Kempisty, Fx 214-943-9407

Respondent: Facility Ins, Attn Katie Foster, Fx 867-1733

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