Envoy Medical Systems, LP
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IRO Certificate #XX

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Letter of Adverse Determination & Peer Review, X, MD, X
Reconsideration Reply & Peer Review, X, MD, X
Physical Therapy Documentation include:
Letter from patient's Physical Therapist; Initial Evaluation & Letter of Medical Necessity; Updated Plan of Care: X, PT, DPT, Therapy XX of X
Physical Therapy Notes/Reports: X:X (and several with illegible dates); X: X
X Functional Scale, X
ODG: “Treatment: Integrated Treatment/Disability Duration Guidelines”; “X”; “Physical Therapy Guidelines”.

PATIENT CLINICAL HISTORY SUMMARY

Patient injured due to X(DOI:X). Diagnosis was X which was noted in X physical therapy progress note. Only critical available notes are from physical therapist and not attending physician. Assessment shows patient had X and X and X pattern and felt physical therapy would benefit X.

Initial evaluation letter of medical necessity, hand written, dated X, very difficult to read the note. The assessment, I believe, is X.

Updated plan of care progress note, discharge note dated X, provider recommended continuing with physical therapy. Another physical therapy note dated X was reviewed as well as X, X, and X. Also reviewed were physical therapy notes dated X.

No further critical documents were available and, once again, no notes from providing physician as well.

Summary: Patient X, sustained a X. X was treated with X. X has had some improvement. X therapist feels X has weakness and stiffness.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION

Opinion: I agree with the benefit company's decision to deny the requested service.

Rationale: No physician documentation available. I am unable to make a decision of medical necessity without physician notes. The requested service is not medically necessary.

DESCRIPTION AND SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION

ACOEM-AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL
MEDICINE UM KNOWLEDGE BASE

AHCPR-AGENCY FOR HEALTH CARE RESEARCH & QUALITY GUIDELINES

DWC-DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES

EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN

INTERQUAL CRITERIA

MEDICAL JUDGEMENT, CLINICAL EXPERIENCE & EXPERTISE IN ACCORDANCE WITH ACCEPTED

MEDICAL STANDARDS X

MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

MILLIMAN CARE GUIDELINES

ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES X

PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR

TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

TMF SCREENING CRITERIA MANUAL

PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE DESCRIPTION)

OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE DESCRIPTION)