Envoy Medical Systems, LP **PH: (512) 705-4647**
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Austin, TX 78758 **IRO Certificate #4599**

PATIENT CLINICAL HISTORY SUMMARY

This is a X who sustained a work related injury in X. X was removing a X. Initial MRI showed a X. X underwent X, X. X then underwent a X. X underwent a X. X also underwent X as well as a X. MRI in X showed failed X and X underwent a X in X. X diagnoses include X, post X use. X is on X, and has also had X. Most recent MRI X showed post- X. Dr. X recommended X, referred X for a X evaluation which found no contraindication for X. Patient's request for X by Dr. X was denied due to ODG not supporting the use of PNS as treatment remains unproven.

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: This review pertains to the need for a X. ODG currently does not recommend this procedure due to insufficient evidence to prove efficacy.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE

CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION (continuation)

Unfortunately, regardless of the clinical situation of this patient, X remains an unproven treatment per ODG and, therefore, not a covered service through the benefit company. The requested service is not medically necessary per these guidelines.

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)