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PH:

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IRO Certificate

PATIENT CLINICAL HISTORY SUMMARY

Patient is X who sustained a X injury occurring C. X underwent X surgery on X and a X on X, with a revision on X. A reviewer states that there was a X. The nurse practitioner stated that there was X pain relief with the duration over X months. The patient submitted a note stating that X pain is a X at all times since X.

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: The nurse practitioner stated that there was more than X months improvement after the X performed in X. Patient's note stated that the pain was at a X level at all times since X. There is inadequate documentation that pain levels and functionality improved after the X. ODG are not met for the requested procedure.

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

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

(continued)

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)