

Envoy Medical Systems, LP
(512) 705-4647
1726 Cricket Hollow Drive
(512) 491-5145
Austin, TX 78758

PH:

FAX:

IRO Certificate

PATIENT CLINICAL HISTORY SUMMARY

Patient is a X who sustained a work-related injury X. X underwent treatment with X. X underwent an MRI. There is no history of X. Initial exam X revealed X.

MRI of the X.

X was noted. X noted. X of the X appear X. X around X. Minimal X noted in the X. Conclusion was X.

Patient initially treated with X.

Patient saw Dr. X. Patient reported pain in the X. Exam showed X. X around the first branch of the X. X noted, X. X-rays of the X. X was diagnosed with X.

It was recommended, as X was unresponsive to non-operative management, that X undergo X. Note dated X from the X states the patient's pain at X and has X. X is also having X.

The surgical procedure was non-certified by Dr. X based on lack of X.

A peer review for surgery was non-certified by Dr. X. X also stated patient had 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: There is no MR evidence of injury to the X. Also lack of MR evidence showing injury to the X. Also, no documentation provided concerning the X.

The requested service, X, is not medically necessary for this patient.

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)