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

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE
X

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION
X

REVIEW OUTCOME
Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

X

INFORMATION PROVIDED TO THE IRO FOR REVIEW
X

PATIENT CLINICAL HISTORY SUMMARY
Patient's requested service, X, was non certified by Dr. X in the initial denial letter, X. X felt that X should be tried for X. The second non certification from Dr. X, was upheld, with Dr. X recommending X.

Clinical notes from Doctor X, X, were reviewed beginning in X. At that time patient reported X. X presented with X. Dr. X noted that the patient had X. On exam X had X.

PATIENT CLINICAL HISTORY SUMMARY (continuation)
X performed X revealed X. MRI of the X performed X revealed X. X was also noted to have X.

Patient was seen again by Dr. X on X, X, X, X, X, X, and additional visits from X until X by Dr. X. X was then referred to a X as well as X. Patient was also X.

Patient then saw Dr. X on X. X chief complaint was of X. X was noted to have X. X was diagnosed with X. It was recommended X under go X.

Patient also saw Dr. X on X for X, comments on diagnosis X. Dr. X agreed with the decision to X.

The patient again saw Dr. X on X, exam was unchanged; x-ray showed X. X was recommended.

X on X performed X showed X.

Followup visit with Dr. X on X, X was recommended.

Summary: X, injuring X on X. Patient was seen by X and treated with X. No X documented. Patient did not receive X. Exam shows X. The recommendation is X. The patient has not 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: I feel the patient has X, not caused by X. I also feel the patient should have X.

The requested service is not necessary at this time 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

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

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)