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Notice of Independent Review Decision

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

X is a X who sustained an injury in X when X. X underwent a X. X underwent a X and X by Dr. X on X. X also underwent a X in X. X of the X on X showed X. X of the X on X showed X. X were present with X. The most recent visit was on X when patient returned to see Dr. X for X with X into the X. Prior treatment includes X. X has had X on X. X stated at the X visit that X saw a X who reviewed X most current X and determined there was "X" and that X would be seeking a second opinion regarding X

options to help relieve this X. X also reported X will be having X, since the X for X. X was noted to be X. Current X are X.

PATIENT CLINICAL HISTORY SUMMARY (continuation)

The request for X was denied previously due to ODG noting X is recommended if the patient is X and has a condition for which the X can be expected to provide substantial benefit and there was no mention of patient being X.

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

Opinion: X AGREE with the benefit company's decision to deny the requested service.

Rationale: This review pertains to the use of X for X. The medical information submitted does not document evidence that the patient is X nor does it define the goals of X in this patient with X with X on X. There is clinical documentation that X is X. There is insufficient information to determine if this patient is X or whether X would benefit X from a X.

The request for X is not deemed a medical necessity 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)