

Envoy Medical Systems, LP  
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IRO Certificate #X

**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**

This is a X patient with a history of X, resulting in X on X by Dr. X. X of X on X showed X. The patient had X since the X with last one documented on X. On X, patient had follow-up appointment with Dr. X, still had X. Request for 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 need for X. ODG cited was for X allowing for X. Number of X even before the X for which X is requested is already over the maximum limit. There is no documentation about why the patient has had X, if further X is planned, and why X would have produced different results than the X.

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

(continuation)

The patient continues with X and X after X. There is some indication that there is X with X in the X but with X. This may be the cause of X but there is no plan on how to address this. There is not enough information to disagree with the benefit company's decision to deny the requested service. **The request for X 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

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)