### Envoy Medical Systems, LP 1726 Cricket Hollow Drive Austin, TX 78758

PH:(512)705-4647 FAX:(512)491-5145

### **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 was X. X presented with X, X, and X pain. X underwent an X. X was referred to Dr. X on X. Dr. X notes indicate that there was an X. This is confirmed on X. X then presented on X complaining of X. Initial denial by Dr.

X on X that X. Dr. X.

Dr. X documented in the X note that X does X. X does request X. The proposed procedures is to X.

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

# ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION (continued)

Rationale: Dr. X excellent note from X indicates that patient has X. X does have X. X also has X. X request for X: prior X. ODG X. It would be reasonable for a X.

The requested service, "X.

# 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)