Envoy Medical Systems, LP **PH: (512) 705-4647**
1726 Cricket Hollow Drive **FAX: (512) 491-5145**
Austin, TX 78758 **IRO Certificate #X**

Notice of Independent Review Decision

DATE OF REVIEW: X

IRO CASE NO. X

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:

Upheld (Agree)

Overturned (Disagree)

Partially Overturned (Agree in part/Disagree in part) X

INFORMATION PROVIDED TO THE IRO FOR REVIEW

X”

PATIENT CLINICAL HISTORY SUMMARY

This is a X, with diagnoses of radiculopathy in the lumbar region with post laminectomy syndrome. Patient complained of lower back pain with radiation down the left leg with burning, numbness, tingling and pain of X. Physical exam on most recent visit with Dr. X on X noted positive straight leg raise with X strength bilaterally and decreased sensation in the left X dermatomes. X had X X. In previous notes there is mention of X seeing a therapist although unclear if this is mental health therapist or physical therapist. Previous treatment has included X. Previous left X. Request was denied initially due to no documentation of physical exam demonstrating neurological deficits, history of X previous X. Initial appeal was denied due to no documentation of physical exam and imaging studies not demonstrating evidence consistent with radiculopathy. Second denial due to no documentation of current active rehabilitation and lack of documentation of previous X.

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

Opinion: I **PARTIALLY AGREE** with the benefit company's decision to deny the requested service, X. 0therwise, patient meets criteria for X.

I PARTIALLY DISAGREE that **IF** the previous date is obtained and there has not been any more than X , **X would meet criteria for a X.**

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

Rationale: This review pertains to the need for a diagnostic and

therapeutic left X, with X. ODG recommend repeat X. A repeat X would require documentation that previous 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

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

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)