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

Notice of Independent Review Decision

x

Decision Amended by Reviewer x*

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) X

Partially Overturned (Agree in part/Disagree in part)

INFORMATION PROVIDED TO THE IRO FOR REVIEW
X

PATIENT CLINICAL HISTORY SUMMARY
This is a X who is a X and sustained a work related injury in X. X. MRI of the right knee on X was X. MRI of the lumbar spine on X apparently showed X. MRI of the right hip was X. Physical exam on X showed X. There is documented X. There was a request for X. The request was certified on X. Clinic note from X by Dr. X shows patient is complaining of right sided lower back pain with radiation into the right posterior leg into the foot with numbness, tingling, and weakness. X is limited with walking and standing. X has completed X. Physical examination shows X. X on the right. It appears a X was performed in the right buttock using X was recommended for diagnostic and therapeutic purposes. Request for X was denied due to “physical examination does not document X.

There is a notice of disputed issue that extent of injury includes X.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION
***Opinion: I DISAGREE with the benefit company's**

decision to deny the requested service.
Rationale: This review pertains to the need for a X. ODG conditionally recommend X as a short term treatment for lumbar radicular pain with corroborative findings of radiculopathy. There is documented X strength right ankle dorsiflexion and plantarflexion on physical exam with positive straight leg raise. Although the MRI lumbar spine report is not available, it is referenced in Dr. X note that there is X. In terms of ODG, there is documented failure of X. There is X. It would have been nice to note great toe extension strength. It does not appear that X has had an X. This treatment should be administered in conjunction with X. There i**s** mention of X in a previous office note.

I believe the requested service, X, is medically necessary, and reasonable, for the 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)