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) X

Partially Overturned (Agree in part/Disagree in part)

INFORMATION PROVIDED TO THE IRO FOR REVIEW
X

PATIENT CLINICAL HISTORY SUMMARY
X who was injured at work on X. X hands were X. Current diagnoses are carpal tunnel syndrome and CRPS of the right arm. The pain radiates from the right hand up to the right shoulder, rated X. On X X was seen for a clinic visit and noted to have X. X has had X. X has had X. First request was denied due to X most current evaluation being X months prior to request date.

There are additional records available, specifically from X and X at X. Patient was seen by X, PA. On X, X describes failure of X. Patient describes swelling, red and purple discoloration and temperature differences between the left and right side. There is nail growth difference. Patient requested X. X states the X. It is documented that the X was on X and the X was on X. At that visit, X was requested. X was started. Future consideration for X was mentioned, X, recommended to X. On X X was seen again. Patient at that visit described that X felt that the X was not performed in the same way as the first.

PATIENT CLINICAL HISTORY SUMMARY (continuation)
The X apparently was more X. The recommendation was X.

ODG allow for 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: Patient *X*. I think it would be reasonable to try X. This was not discussed in the plan but would meet criteria for X per the ODG.

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)