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

***AMENDED "ANALYSIS & EXPLANATION" OF DECISION" (pg. 4)**

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 X with X. X had X. In previous notes there is mention of X seeing a therapist although unclear if this is X. Previous treatment has X. Previous X noted over X relief with functional improvement and medication utilization decrease over X months. Request was denied initially due to X. Initial appeal was denied due to X. Second denial due to 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 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 X. ODG recommend X. A X would require documentation that X.

(AMENDED)
*The requested service(s) “X” is 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)