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

PH: (512) 705-4647
FAX: (512) 491-5145
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
This is a X who sustained a work related injury to the lower back when X was X. X had X. X had X. Lumbar MRI on X revealed X. X changes. X had a X on X with X improvement.

Requested procedure for X was denied due to no duration of pain relief documented. Surgical consult was done with Dr. X recommending X but wanted X to get 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 recommend X. A X would require documentation that previous X produced a minimum of X pain relief and improved function for at least X weeks. There is documentation of X pain relief but the duration of relief is not specifically stated, which was the reason for the denial. There are two factors to consider....One is that the patient has not needed an X since X, which would imply a duration of pain relief longer than X weeks. The other is that the alternative is X which was recommended by the spine surgeon, Dr. X but even X recommended the X. Given these factors, I would recommend proceeding with the .**X**
The requested service,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)