Envoy Medical Systems, LP **PH: (512) 705-4647**
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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

This is a X who sustained a work related injury in X, when X was X. X was diagnosed with wedge compression fracture of X vertebra. The patient complained of back pain that radiates into the left hip with difficulty walking, rising, and driving. Physical exam on X documented left X joint tenderness, pain with X. Per that note, X has had X pain well controlled. X has had TLSO brace, medications, and activity restrictions. X was then seen by X, APRN, on X, and complained of continued pain with radiation into the buttock. Exam findings included 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 do allow for X. They do specifically not recommend diagnostic X. With the lumbar MRI showing just a small left X. One option would be to get an MRI of the X. EMG has also been suggested for X. This treatment should be administered in conjunction with active rehabilitation efforts including current physiotherapy and/or a

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

continuing home exercise program. I would agree with proceeding with a X for not only diagnostic (not allowed by ODG), but more importantly therapeutic purposes.

The requested service, X, is medically necessary and reasonable for this patient.

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)ACOEM-AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGE BASE

AHCPR-AGENCY FOR HEALTH CARE RESEARCH & QUALITY GUIDELINES

DWC-DIVISION OF WORKERS COMPENSATION POLICIES & QUALITY GUIDELINES

EUROPEAN GUIDELINES R 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