

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

PH:

FAX:

IRO

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) X

Overtured (Disagree)

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 injured in a X. X was authorized X. The patient apparently had X. Initially, X was requested on X. OT note on X showed patient X. Peer review physician denied the X. There is a request for X submitted on X which was approved.

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

Opinion: I AGREE with the benefit company's decision to deny the requested service.

Rationale: This review pertains to the need for X. ODG cited was X. There is some confusion about the plan of care as there is a X approved for the patient as of X. There is no documentation of the benefit of the X. There is not enough information to disagree with the benefit company's decision to deny the requested service. I would agree that a re-evaluation of this request would be indicated after the surgery has been completed.

X, is not medically necessary 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)