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Certificate #4599

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)

Overtured (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 who sustained an injury in X, who is now s/p complex left upper extremity wrist/forearm laceration repair including ulnar nerve/artery repair performed by Dr. X on X. X has completed X. Patient reported difficulty with use of X left upper extremity for lifting, carrying, gripping, reaching, dressing, grooming, cleaning home, yard work, phone/tablet use, and work related tasks. X had met X short term goals and was progressing well with remaining goals. The treatment plan was to continue with X. Additional sessions were non-certified due to ODG recommending X. Most recent OT note from X shows patient has met X short term goals and has had X.

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

Opinion: I agree/disagree partially with the benefit company's decision to deny the requested service.

Rationale:

Agree in Part: This pertains to the need for X. **ODG was**

cited recommending X. The requested service, “X”, is not medically necessary.

Rationale:

Disagree in Part: However, this patient's injury also involves X. I would agree that a re-evaluation of the request for **X would be indicated and is appropriate and 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