Envoy Medical Systems, LP **PH: (512) 705-4647**
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Austin, TX 78758 **IRO Certificate X**

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 patient who sustained a work related injury in X, when X. The patient has a diagnosis of chronic pain, lumbar radiculopathy myalgia/myositis, post lamenectomy syndrome, spasm, cervical radiculopathy, pain in the thoracic spine, headaches, essential hypertension, and long term current use of opiate analgesic drug. Most recent MRI of the lumbar spine X showed X. Patient also has history of X. Patient complained of limited range of motion in the neck, daily headaches. On X, Dr. X and X PA X documented patient complaining of lower back pain into bilateral lower extremities, but specifically radiation into the RIGHT buttock and down the RIGHT leg and pins and needles into the LEFT thigh. Abnormal strength was documented with no specific myotome documented. On X, patient was seen by X, NP. The is documented as being on X. It is documented in that note X is having cervical pain that radiates into the RIGHT shoulder and lumbar pain that radiates into the LEFT lateral thigh and LEFT anterior thigh. There is documentation of denial of denial of imaging of the neck (MRI). Dr. X recommended X. Initial denial due to “successful peer to peer with treating provider being required for modification”. X denied due to no documentation of X.

PATIENT CLINICAL HISTORY SUMMARY (continuation)
Appeal denial due to X. X denied due to ODG specifically not X.

OPINION: Request for X. I **disagree** with the benefit company's decision to deny the requested service. This request is medically necessary for patient.
OPINION: Request for X. I **agree** with the benefit company's decision to deny the requested service. This request is not medically necessary for patient.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION
RATIONALE: This review pertains to the need for X**.** ODG conditionally recommend X. This treatment should be administered in X. These conditions are cited in the patient's letter to the benefit company and X mentions X did have an X. There are correlating findings of X. There is documentation of goal to X. There is documented X**.** **There is also no documentation of X.** I ***do*** think it would be reasonable to try one X.

This review also pertains to the need for X**.** ODG specifically do X. Patient's note describes radicular pain down the right arm with MRI imaging denied recently. Furthermore, X. As it sounds like X has cervical radiculopathy, would **agree with denial of X**.

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)