

**Envoy Medical Systems, LP**  
**(512) 705-4647**  
**1726 Cricket Hollow Drive**  
**(512) 491-5145**  
**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**

**Repeat:**

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 involved in a motor vehicle accident wherein X drove into a ditch and bounced back out. X was able to crawl out of X vehicle but could not stand or walk. X sustained a X. On X had a MRI of the lumbar spine that showed X. On X was not approved per peer review. An updated CT scan showed X. X was approved on X. X were approved on X. MRI on X showed X. Dr. X recommended X. Peer review was performed on X which noncertified the X due to both use of X, but also due to reported X. On X request for the X were certified. Peer review on X noted that there was X. X notes indicate patient got X.

### **PATIENT CLINICAL HISTORY SUMMARY** (continued)

X was then approved and performed on X. X then followed up with Dr. X on X and reported great relief of pain (completely resolved) X was requested. X was denied due to not meeting time frame criteria for X. It is documented that X got complete pain relief from X on X and was able to return to work for X weeks but then X was unable to continue to work after X weeks.

## **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 a X. ODG conditionally recommend X. Patient *did* get complete relief of X pain and was able to return to work for X weeks following the X. However, X is within the X months window since X. **Would recommend re-requesting the X.**

**The denied service(s): Repeat: “X”, is not medically necessary at this time.”**

**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)