

Envoy Medical Systems, LP

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IRO

Certificate

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)

Overtaken (Disagree) X

Partially Overtaken (Agree in part/Disagree in part)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

X

PATIENT CLINICAL HISTORY SUMMARY

The patient, X, was X. X suffered a X. X has continued to have headaches and imbalance issues. X has been diagnosed with an Adjustment Disorder with Major Depression and Post Traumatic Stress Disorder.

X has complied with X medical course of treatment as well as following up with X. X

continues to suffer with psychological issues related to X. X treating psychologist, Dr. X, has requested 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.

Summary of reasons/rationale: X was X. X needed X.

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

Post-injury symptoms included blurred vision, loss of hearing, difficulty with balance, coordination, pain headaches, difficulty with memory, dizziness, trouble concentrating and emotional regulation issues. Testing showed X scores were significantly elevated and indicate

that X anxiety and depression are likely influenced by X pain and had a negative response to X treatment.

X psychological care focused on individual psychotherapy. X treating psychologist has requested an X. This is a reasonable request given the severity of X injuries.

The requested service: “**X**” is reasonable and **medically necessary for this 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) X**