Envoy Medical Systems, LP **PH: (512) 705-4647**
1726 Cricket Hollow Drive **FAX: (512) 491-5145**
Austin, TX 78758 **IRO Certificate X**

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**

Overturned (Disagree)

Partially Overturned (Agree in part/Disagree in part)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

X

PATIENT CLINICAL HISTORY SUMMARY

Patient with injury date of X, has been denied the following requested services; X, as being medically unnecessary. Utilization Review from Dr. X, X, non-certified the requests due to lack of documentation concerning osteoarthritis on the XR imaging, being greater than X years of age, and a body mass index less than X, lack of documentation concerning X. Due to lack of certification of the requested X were non-certified.

Appeal Letter dated X, by Dr. X, MD, also non-certified the appeal for requested services: X. Appeal letter states claimant does not meet the evidence based guidelines for criteria to support the request, that the patient's documents do not show evidence of X, guidelines recommend surgery for those over X years of age. Failures of non-operative measures, such as X, are not detailed. Current BMI were not detailed. Again, request for X were non-certified because the requested X was non certified.

The note also states that the patient did have a work injury in X, (mechanism of injury not detailed in records) and had X

PATIENT CLINICAL HISTORY SUMMARY (continuation)
. No other records detailing these surgeries were included for review. Note states patient had used X. No other treatment records were included for review. Note also states patient had X.

A clinic note from Dr. X, MD, dated X, states follow up for knee pain. Patient's height is documented as 5ft 7in, but no weight is documented. Also documents medication: X. Reviewed problems: X.

History of present illness: Existing injury condition is worse; pain scale while resting, X; pain scale while active, X. Pain is worse while walking and bending, duration X yr. X months. X does not participate in X. States patient has had imaging studies done in previous surgeries, and uses assist device. Note also states the X. Patient has been undergoing X. X also underwent a X.

Social History: States X is former smoker, years smoking tobacco, X year, but states X smokes X pack per day. Moderate alcohol consumption, currently unemployed.

Surgical History: X

Physical exam right lower extremity: Surgical incisions are clean, dry, intact, and well-healed; range of motion is X to X; X. Assessment: post-traumatic arthritis in the right knee.

The plan was to proceed with X. Also noted patient should under X.

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(s).

Rationale: I feel that documentation concerning patient's BMI, tobacco use status, X. Also needed would be imaging documentation of severe arthritis of the right knee.

The requested service(s): "X" **is not medically necessary or appropriate 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

DESCRIPTION AND SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION

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)