

Envoy Medical Systems, LP

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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)

Overtaken (Disagree) X

Partially Overtaken (Agree in part/Disagree in part)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

X

PATIENT CLINICAL HISTORY SUMMARY

X who sustained an injury on X and was diagnosed with X herniated disc which ultimately required surgery on X. There is a note on X that Sedgwick denied X. X followed up with Dr. X on X and X documented that a X would be reserved for recalcitrant pain. On X, X followed up complaining of more pain and some anxiety and had a CT myelogram at an outside facility which showed X. X dose was raised. On

X saw Dr. X and complained of chronic neck, right shoulder, arm and hand pain that improved over a year ago after a X. Patient reported more than X reduction in pain shooting sensations, improved function and decreased medication but now the pain has increased back up to X and X has had to increase X. X is complaining of decreased neck range of motion and pain with flexion, decreased strength on the right grip. Requested X. Initial request denied due to no documentation of the most recent trial of conservative care. ODG allow for X. Procedure was also denied due to request for X which is not recommended per ODG.

**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.

Rationale: Dr. X excellent note from X indicates that patient has had X. X does have imaging

AFTER X which shows X. X request for X: X. ODG do allow for X when required for extreme anxiety, although sedation is generally not recommended.

The requested service(s): “X” is reasonable and medically necessary for the 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)

OTHER EVIDENCE BASED,
SCIENTIFICALLY VALID, OUTCOME
FOCUSED GUIDELINES (PROVIDE
DESCRIPTION)