

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

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

Patient is X, birth date X, who has been denied X by Dr. X. Diagnoses listed was sprain of medial collateral ligament of right knee, history of X.

Adverse Determination Letter for non-certification dated X reviewed by X, MD. Dr. X states that X is not indicated. The note does mention X.

Reviewed an Appeal Request dated X by Dr. X, listing the X. Also reviewed an Appeal Request/Peer Review dated X by X, MD, who also non-certified the request stating X is not needed.

Also reviewed progress note dated X by Dr. X stating patient complains of right knee pain. X had a previous X. Patient reports X. X reports soreness in the leg for a week and that knee feels warm to touch and is sensitive associated with swelling and limping. Dr. X exam shows X. Assessment is sprain of lateral collateral ligament of right knee, history of X. Note also X. Note does not mention X.

PATIENT CLINICAL HISTORY SUMMARY (continuation)

Reviewed XR report, Right Knee, X by Dr. X. Compared to previous XR of X, 2 views of the knee showing X; X. Note states X.

Summary of events: X year old X with 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.

Rationale: X. I recommend the surgeon resubmit for X is necessary, there needs to be documentation supporting this in the records.

The requested service: “X”, is not medically necessary.

**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)