

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

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) X

Overtaken (Disagree)

Partially Overtaken (Agree in part/Disagree in part)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

X

PATIENT CLINICAL HISTORY SUMMARY

This is a X patient who sustained a work related injury on X. X is

X.

Most recent note from X shows X is having severe back pain radiating down X legs with difficulty walking. X had a X. X also underwent a diagnostic X. X has tried X. Initial request was for X. X went to the ER with severe pain, also complaining of urinary fecal incontinences; there is a X ordered by Dr. X, neurosurgeon pending. First denial was due to X.

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

Opinion: I agree with the benefit company's decision to deny the requested service(s).

Rationale: This review pertains to the need for X. ODG conditionally recommend X. This treatment should be administered in X. There are no imaging studies done after the acute onset severe pain and fecal and urinary incontinence, which is concerning for X. I agree patient needs a X. Without a correlating finding, a X is not indicated.

The requested service(s), “(X” is not indicated or 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)