

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

Overtaken (Disagree)

Partially Overtaken (Agree in part/Disagree in part)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

X

PATIENT CLINICAL HISTORY SUMMARY

Patient is a X who sustained an injury in X when X. X had an X on X which showed diagnoses of right knee contusion and sprain of thoracic and lumbar spine and contusion of chest wall. X pain was rated X according to most recent consult note on X. Patient reported anxiety and depression secondary to the work injury. X identified X. There is a X with dispute for the diagnoses of X. Request was made for

X. The patient had X. X treating doctor stated that the patient is at a sedentary physical demand level with the biggest problem of pushing and pulling more than X lbs. The work PDL is light. Recommendation was made to non-certify 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: This review pertains to the need for a X for diagnosis of thoracic and lumbar strain/sprain and right knee and rib contusion on X. Per ODG, X. X has demonstrated that the patient is at sedentary capacity but X work is also low PDL. X has had X

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

DECISION (continuation)

X. I agree with the recommendation for trial of return to work as X work PDL is light and X is cleared for sedentary work per X.

The requested service(s), “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)