

Envoy Medical Systems, LP
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PH:

FAX:

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)

Overtaken (Disagree) X

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 with history of X who sustained a work related injury on X after X. There is a denial of X, visits X on X by Dr. X.

Subsequently there was a denial for a X to be performed by Dr. X on X. Lumbar spine MRI on X showed a X. No X noted on either X. Xray of the spine showed X. Request specified that patient has not improved X. X was denied due to X. Dr X note from X details that X has pain with sitting longer than an hour. X note does note that X has a right lateral shift, difficulty bending forward, having muscle spasms, and burning pain in the mid lumbar spine which started after the injury. X is unable to lift or sit due to the pain.

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(s).

Rationale: This review pertains to the need for a X. ODG conditionally recommend X. This treatment should be administered in conjunction with X. There is documentation of X. Although X does not have X. In terms of ODG, there is documented X. It does not appear X has had an X. I would agree with proceeding with a X.

The requested service(s): "X", X, performed by Dr. X, is 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 ADV

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)