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**
Overturned	(Disagree)
Partially Overturned	(Agree in part/Disagree in part)

INFORMATION PROVIDED TO THE IRO FOR REVIEW
X
PATIENT CLINICAL HISTORY SUMMARY

Request for X. Non-certified.
Adverse determination letter by Dr. X. Review of History and Physical and MRI findings. Dr. X concluded MRI of the left ankle dated X reveals a X. ODG would support surgical intervention for ankle sprain and ankle instability X.. Failure of X patient's X including physical immobilization has not been completed and no corresponding laxity noted on physical examination. Therefore, the formal request was non-certified.

Appeal Adverse Determination, X, by Dr. X, MD, non-certified, stated X. Dr. X did speak to Dr. X on X, and Dr. X suggested they could proceed with X. Overall, Dr. X concluded that the request for services were to be non-certified.

A patient related progress note generated by Dr. X, X, stating patient was X. On exam X was noted to be X. Diagnosed with a sprain of left ankle; stress views **were recommended** and possibly an MRI.

PATIENT CLINICAL HISTORY SUMMARY (continuation)
Office visit notes with Dr. X, DC, beginning X through X. In total there were X. There were no exam findings in the notes from Dr. X. MRI report of X, read by Dr. X, MD, X. X.

Summary: A X. Exam shows X. No X. MRI shows X.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION
Opinion: X.
Rationale: X. X.

The denied service(s), "X)" are not 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)