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)

Overturned (Disagree) X

Partially Overturned (Agree in part/Disagree in part)

INFORMATION PROVIDED TO THE IRO FOR REVIEW
X

PATIENT CLINICAL HISTORY SUMMARY

This case involves a X who suffered a X. X has X. Despite therapy, X has declined. X treating neurologist has requested approval for an X. It has been denied.

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.

Summary/Rationale for Opinion:

The patient has declined and needs additional care. X ADLs (Activities of Daily Living) are compromised. X condition requires an X. This X can reduce the need for long term support. Additionally, X meets **multiple ODG criteria for X. Clearly, the requested service, "X" is both appropriate and medically necessary for this 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)

Disclaimer:
The opinions rendered in this clinical case are the opinions of this reviewer. The evaluation was conducted on the basis of the medical documentation as provided with the assumption that the material is true and correct. All of the opinions that are given in this report have been given within a reasonable degree of medical probability. If more information becomes available at a later date, then additional service, reports or reconsideration may be requested. Such information may or

may not change the opinions rendered in this evaluation. The opinion is based on a clinical assessment from the documentation provided, my clinical judgement, medical science, and accepted practices-evidence-based medicine.