

Envoy Medical Systems, LP
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1726 Cricket Hollow Drive
(512) 491-5145
Austin, TX 78758
Certificate #X

PH:

FAX:

IRO

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

Physician Board Certified X

REVIEW OUTCOME

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

Upheld

(Agree)

Overturned (Disagree)

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

INFORMATION PROVIDED TO THE IRO FOR REVIEW

X

PATIENT CLINICAL HISTORY SUMMARY

I have recently been able to review the medical information you forwarded to me concerning case file X, patient X. This is a X patient who sustained a work related injury on X when X attempted to prevent a resident from falling. Initial injury was to the left shoulder and lower back. X had xrays that showed X. X had X. X had an MRI on x showing X. Pain management referral was initiated. Dr. X noted X. X was recommended X. X was denied due to X. Appeal was denied due to Dr. X note indicating left sided symptoms (my review of X most recent note from X indicates X). There was also mention of a X which was performed but Dr. X note from X documents that this was never performed.

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

Opinion: I partially disagree in part with the benefit company's decision to deny the requested service(s) and partially agree in part with the benefit company's

decision to deny the requested service(s).

**SUMMARY OF REASONS/RATIONALE FOR
OPINION(S):**

This review pertains to the need for X. ODG conditionally recommend X. This treatment should be administered in X. There is mention of patient X. There is documented X. It **does not** appear patient has had X in the past. I do think it would be reasonable to try X to see if X is able to X. For these reasons, I **disagree with the benefit company's denial of X**

ODG do not recommend X for this procedure. Thus, I **agree with the benefit company's decision to deny X.**

The requested service **X**, **is medically necessary.**

The requested service **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)

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.