Envoy Medical Systems, LLC
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IRO Certificate #4599

NOTICE OF INDEPENDENT REVIEW DECISION

November 11, 2002

Re: IRO Case # M5-03-0354 _____-

Texas Worker's Compensation Commission:

Envoy Medical Systems, LLC (Envoy) has been certified as an independent review organization (IRO) and has been authorized to perform independent reviews of medical necessity for the Texas Worker's Compensation Commission (TWCC). Texas HB. 2600, Rule133.308 effective January 1, 2002, allows a claimant or provider who has received an adverse medical necessity determination from a carrier's internal process, to request an independent review by an IRO.

In accordance with the requirement that TWCC assign cases to certified IRO's, TWCC assigned this case to Envoy for an independent review. Envoy has performed an independent review of the proposed care to determine if the adverse determination was appropriate. For that purpose, Envoy received relevant medical records, any documents obtained from parties in making the adverse determination, and any other documents and/or written information submitted in support of the appeal.

The case was reviewed by a physician who is Board Certified in Anesthesiology and Pain Management. He or she has signed a certification statement attesting that no known conflicts of interest exist between him or her and any of the treating physicians or providers, or any of the physicians or providers who reviewed the case for a determination prior to referral to Envoy for independent review. In addition, the certification statement further attests that the review was performed without bias for or against the carrier, medical provider, or any other party to this case.

The Envoy reviewer who reviewed this case has determined that, based on the medical records provided, the requested treatment was not medically necessary. Therefore, Envoy agrees with the adverse determination regarding this case. The reviewer's decision and the specific reasons for it, is as follows:

History
The patient is morbidly obese with chronic low back and leg pain since a 1994 injury.

Psychological issues are present. The patient has not responded to numerous injection procedures.

Requested Service(s)
CPT codes 62287, 76001-26, 64442, 64443-50, 76000-26, 00630-46, 99214, 99214 on dates 10-22-01 through 6-5-02

Decision
I agree in part and disagree in part with the carrier's decision to deny the requested services.

Rationale
I agree with a previous reviewer that the invasive treatment has been excessive. The laser diskectomy and fluoroscopy code is reasonable since that is a procedure used to treat contained disk herniations. The documentation provided no indication for the charges on 12/11/01. Since the patient had signs and symptoms of radicular pain, facet injections were not reasonable or necessary.
Office visits on 1/3/02, 6/5/02 are reasonable and necessary to manage medications. There is adequate documentation to support the coding.
There is little likelihood that additional injections would be of any benefit to the patient.

This medical necessity decision by an Independent Review Organization is deemed to be a Commission decision and order.

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the decision and has a right to request a hearing. A request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision (28 Tex. Admin. Code 148.3). This decision is deemed received by you 5 (five) days after it was mailed (28 Tex. Admin. Code 102.4(h) or 102.5(d). A request for a hearing should be sent to: Chief Clerk of Proceedings, Texas Worker's Compensation Commission, P O Box 40669, Austin, TX 78704-0012. A copy of this decision should be attached to the request.

The party appealing this decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute.

Sincerely,

_____
Daniel Y. Chin
President