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IRO Certificate #4599

Notice of Independent Review Decision

DATE OF REVIEW: 6/28/11

IRO CASE #:

Description of the Service or Services In Dispute
SI joint injection

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION

Physician Board Certified in Orthopedic Surgery

REVIEW OUTCOME

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

X Upheld	(Agree)
Overtured	(Disagree)
Partially Overtured	(Agree in part/Disagree in part)

Description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute

Information Provided to the IRO for Review
ODG guidelines
Adverse determinations 6/10/11, 6/9/11, 4/22/11
DDE report 10/27/10, Dr.
FCE reports 6/23/10, 9/16/09
Radiology reports 2/24/10, 10/27/09
Occupational Profile 9/16/09
Ultrasound report 3/27/09
Discography report 12/11/08
Operative reports, 9/18/09, 4/19/10, 3/16/09
Consultation report 4/13/10
Physical therapy records 2008-2009
Laboratory reports
Back Institute notes 8/2009 – 5/2011

PATIENT CLINICAL HISTORY [SUMMARY]:

Summary of events: The patient apparently sustained a slip and fall injury in xx/xxxx, and had low back pain. The patient underwent a lumbar fusion in March 2009 and hardware removal in May 2010. She was treated with extensive physical therapy. She continues on significant medication, and continues to have back and leg pain. Apparently the treating physicians felt that SI joint injections would be of benefit.

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

I agree with the non-certification for the SI joint injections. The medical records provided for review suggest that this is a patient with failed back syndrome. I see no significant clinical documentation as to why SI joint injection would be of further significant benefit. In cases such as this, rehabilitation and psychological counseling can be helpful in returning patients to a more functional status.

Disclaimer: opinions rendered in this case are the opinions of the evaluator and are rendered based on medical documentation provided with the assumption that the documents are complete and correct. This evaluation is opinion based on clinical assessment from the documentation provided. 6/22/11.

DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE
- AHCPR- AGENCY FOR HEALTHCARE 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 AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS
- MERCY CENTER CONSENSUS CONFERENCE GUIDELINES
- MILLIMAN CARE GUIDELINES
- ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES
- PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR
- TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS
- TEXAS TACADA GUIDELINES
- TMF SCREENING CRITERIA MANUAL
- PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)