

Envoy Medical Systems, LP
4500 Cumbria Lane
Austin, TX 78727

PH: (512) 836-9040
FAX: (512) 491-5145
IRO Certificate #4599

Notice of Independent Review Decision

DATE OF REVIEW: 8/27/13

IRO CASE NO.

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

1 Left sacroiliac Joint Injection under flurososcopic guidance between 7/29/13 and 9/27/13

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

Physician Board Certified Physical Medicine & Rehabilitation

REVIEW OUTCOME

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

Upheld	(Agree) <input checked="" type="checkbox"/>
Overtured	(Disagree)
Partially Overtured	(Agree in part/Disagree in part)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Adverse Determination Letters (3), 8/02/13, 7/02/13, 4/16/13
Peer Review, 'EBME' (Evidence Based Medical Evaluators), 4/02/13
Peer Review, 8/01/13
Peer Review, 2/14/13
Clinic Notes (6) 7/29/13, 7/01/13, 5/20/13, 5/10/13, 4/08/13, 2/14/13; Procedure Orders (2), 2/01/13;
Clinic Notes (3) 11/30/12, 11/09/12, 10/05/12
Medical Evaluation, 3/05/13
Manual Muscle Strength Examination (Lumbar) (3); 7/01/13, 2/14/13, 2/01/13
Diagnostic Notes (2012); One Step Diagnostic: (3), 12/31/12, 11/13/12, 11/13/12; X-Ray Thoracic & Ribs (1), 10/05/12; NM Bone Scan Limited (1), 9/12/12
Daily Progress Notes (9), 4/14/13, 1/03/13
Initial Medical Report, 9/17/12
Operative Notes (2): LMBB Op. Rpt, 3/25/13; SII Op. Rpt. (w/att. X-ray); 2/01/13;
ODG (Official Disability Guidelines)

PATIENT CLINICAL HISTORY SUMMARY

This is a male who was injured in xx/xxxx. He had fractured ribs at right T9 and T10, and a fractured third segment of the coccyx. He underwent physical therapy, chiropractic treatments, and steroid injections. He also had a left sacroiliac injection (2/01/13) with limited response reported. A left medial branch block was performed 3/25/13, also with limited response. A second SI injection has been requested, previously reviewed and denied.

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

Decision: I agree with the benefit company's decision to deny the requested service. **Rationale/Reasoning:** The previous denials, including 7/22/13 and 8/02/13, have been reviewed. There was also a review of the

hip and pelvis chapters in the ODG concerning SI injections/repeat injections. The ODG is fairly straightforward concerning a need for significantly positive response to the first injection which was not achieved in this case. The guidelines state ***“can repeat blocks provided at least there's a greater than 70% pain relief for 6 weeks.”***

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

TEXAS TACADA GUIDELINES

TMF SCREENING CRITERIA MANUAL

PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE DESCRIPTION)

OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES
(PROVIDE DESCRIPTION)