Envoy Medical Systems, LP
1726 Cricket Hollow Drive
Austin, TX 78758

PH: (512) 705-4647
FAX: (512) 491-5145
IRO Certificate #4599

DATE OF REVIEW: 4/23/18
IRO CASE NO. XXXXXX

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE
Left, SI Joint Injection, CPT 27096

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION
Physician Board Certified in Anesthesiology & Pain Management

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)

PATIENT CLINICAL HISTORY SUMMARY
This XX individual sustained a back injury in XXXX, while attempting to XX. Conservative treatment including over the counter medications and physical therapy have been completed. A left sacroiliac joint injection was performed previously that provided 80% pain relief for XX. This individual is working full time; the pain has recurred. Previous reviewers have denied the request based on lack of documentation of increased functionality.

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.

Rationale: XX, in XX office visit note of XXXX, adequately documents improvement in functionality after the left SI joint injection. XX states that the patient's function with injection resulted in better XX work; patient does much XX at work. XX can XX and is able to walk longer distances with improved sleep. Since the last injection has worn off, XX has had pain flare-up which has limited XX current work capacity. This is verbatim. XX continues to work at a XX.

Additional comments: The question regarding functionality after SI joint injections has been addressed and there is well documented functional improvement. ODG does not endorse SI joint injections for non-inflammatory sacroiliac conditions, but there is inadequate data to categorically deny a procedure.

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 JUDGMENT, 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)