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

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

DATE OF REVIEW: 12/19/17

IRO CASE NO. XXXX

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE
Left, Injection Tendon Sheath/Lig/Trigger Pt/Gangl, Fluoroscopy, 1 hour, 20550, 76000

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:

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

PATIENT CLINICAL HISTORY SUMMARY

Patient is a XXXX who sustained an initial work injury to the left ankle in XXXX. Patient underwent left ankle arthroscopic debridement in XXXX & XXXX; Left peroneus brevis repair in XXXX; Left ankle arthroscopic debridement, partial synovectomy, treatment of medial talar dome osteochondral injury with debridement, microfracture and application of synthetic cartilage in XXXX.

Patient presented to XXXX office XXXX complaining of pain on the lateral side of the ankle. Physical exam showed a normal gait. Healed incisions were noted. Ankle range of motion good with normal strength. Tenderness over the course of the peroneal tendons. Tendons stable with circumduction.

MRI of the left ankle performed without contrast, XXXX, shows osteochondral lesion medial aspect talar dome. There is reactive edema. There are subcortical degenerative cysts. There is no evidence of tendon or ligament abnormality.

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

Opinion: I agree with the benefit company's decision to deny the requested service.

Rationale: The MRI performed in XXXX, shows no evidence of tendon or ligament abnormality justifying the need for cortisone injection into the tendon sheath. A cortisone injection into a tendon sheath is not a benign and riskless procedure and, therefore, not indicated for this patient.

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)