

# P-IRO Inc.

An Independent Review Organization  
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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE NOTICE SENT TO ALL PARTIES:**

Dec/23/2013

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**

Peripheral nerve ablation at SI level (SI joint radiofrequency neurotomy)

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

Anesthesiologist

Pain Medicine

**REVIEW OUTCOME:**

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

Upheld (Agree)

Overturned (Disagree)

Partially Overturned (Agree in part/Disagree in part)

**Provide a description of the review outcome that clearly states whether medical necessity exists for each health care service in dispute.**

**INFORMATION PROVIDED TO THE IRO FOR REVIEW:**

ODG - Official Disability Guidelines & Treatment Guidelines

Utilization review determination dated 10/23/13, 11/27/13

Letter dated 12/13/13, 11/20/13

Message log dated 10/16/13

Spinal injection score sheet dated 08/16/13

Patient history information dated 08/16/13

Visit note dated 08/16/13

New patient evaluation dated 06/27/12

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The patient is a female whose date of injury is xx/xx/xx. The patient was stuck against the wall. She was found to have pelvic fractures. Visit note dated 08/16/13 indicates that the patient complains of low back pain. Treatment is noted to include physical therapy that only helped with core strengthening. The patient underwent SI joint injection on this date.

Initial request for peripheral nerve ablation at SI level (SI joint radiofrequency neurotomy) was non-certified on 10/23/13 noting that the physical examination was somewhat incomplete. There were no imaging studies or other assessments to establish the exact nature of the pathology. A single injection into the sacroiliac region had been completed; however, there is no follow up note suggesting the efficacy or utility of such a procedure. As outlined in the ODG, such an appellation procedure is under study as there is some conflicting evidence

relative to the efficacy of this type of procedure. The denial was upheld on appeal dated 11/27/13 noting that clinical guidelines do not support the clinical efficacy of this procedure as well as the lack of documentation of the response to the intraarticular corticosteroid injection of the left SI joint.

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

The patient sustained injuries on xx/xx/xx and subsequently underwent SI joint injection on 08/16/13. The patient's objective, functional response to this procedure is not documented to establish efficacy of treatment. There is no current, detailed physical examination submitted for review. The Official Disability Guidelines do not recommend SI joint radiofrequency neurotomy noting that larger studies are needed to confirm these results and to determine the optimal candidates and treatment parameters for this poorly understood disorder. As such, it is the opinion of the reviewer that the request for peripheral nerve ablation at SI level (SI joint radiofrequency neurotomy) is not recommended as medically necessary.

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

ACOEM-AMERICA 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)