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Notice of Independent Review Decision
Amendment X

IRO REVIEWER REPORT

Date: X; Amendment X

IRO CASE #: X

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:X.

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

REVIEW OUTCOME:

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

☐ Overturned Disagree

☐ Partially Overtuned Agree in part/Disagree in part

☒ Upheld Agree

INFORMATION PROVIDED TO THE IRO FOR REVIEW: • X

PATIENT CLINICAL HISTORY [SUMMARY]: X who was injured on X. X stated that X pain started in X when X. X went to X, which did improve the pain. X then reinjured X back in X with X. The diagnosis was lumbar sprain; displacement of lumbar intervertebral disc without myelopathy; radiculopathy, lumbar region; and migraine. On X, X was seen by X, MD for a follow-up visit for low back and right leg pain. (The note was amended by Dr. X on X). X had been referred by Dr. X for a history of lower back pain with radiation to the right buttock and posterior leg occasionally into the calf. X stated X pain started in X when X. X went to X, which did improve the pain. X then reinjured X back in X with just X. This again improved with X. X was doing well until X where X reinjured X back X. X described lower back pain with radiation to X right posterior leg into X ankle that X described as an aching, stabbing-type pain with occasional pins and needle sensation. X had been to X again with this episode; however, X continued with pain. X did not describe medications for pain as X did not like the way they made X feel. X continued working full time for the X. X denied any X. X also got pain in the lower back area that radiated across X waistline. X had a recent lumbar MRI and had been referred for further pain management. X had not had X. At the time, X continued with primarily axial low back pain. X leg pain did not go below X knee. X had a recent X that was denied. X continued working full-time for the X. X denied any X. This was worsened with certain activities like sitting and bending forwards. On examination, blood pressure was 125/91 mmHg, weight 198 pounds and BMI was 30.2 kg/m2. The lumbar / lumbosacral spine examination revealed X. There was X. Strength examination revealed X. X lumbar MRI images and report were reviewed. The assessment was X was requested. X did not desire X. X was determined not to initiate X. X was to consider referral to a X. X would continue X home exercise program as instructed during

prior X. X would continue working as tolerated as a X. X would follow up with Dr. X as scheduled for X occupational medicine follow-up. An MRI of lumbar spine dated X revealed X. This was not significantly changed from the previous study. There was X. This had mildly worsened since the previous study. Per an addendum dated X, the MRI showed X. Treatment to date included X. Per a utilization review adverse determination letter dated X by X, MD, the request for X was denied. Rationale: "Per ODG by MCG, 'X..Not recommended. Despite promising early reports, further X. If approved despite non-recommendation, there should be X.' The patient is a X who sustained an injury on X. The requested procedure is X. Moreover, the lumbar spine magnetic resonance imaging (MRI) report includes X. The clinical trials of this procedure excluded participants with X. The request is not shown to be medically necessary. As such, the requested X is denied. Per ODG by MCG, 'X...Not recommended. Despite promising early reports, further trials with X. If approved despite non-recommendation, there should be at X.' This procedure is not currently recommended as a X. Moreover, the lumbar spine magnetic resonance imaging (MRI) report includes no mention of X. The clinical trials of this procedure excluded participants with X. The request is not shown to be medically necessary. Therefore, the requested X is denied." In an appeal letter dated X, regarding the request of X, X, MD, wrote, "I am filing an appeal on behalf of my patient, X, for wrongful denial for X. This procedure fills a treatment gap for those patients that do not receive X. X had X. As such, I strongly disagree with your decision. Your claim of requiring more evidence so it is not considered investigational and experimental is not appropriate, particularly given there is sufficient science published in peer-reviewed publications. This procedure improves the quality of life of patients suffering from X. The X, not just the device received initial FDA clearance the summer of X. That clearance means the procedure is safe and effective. We have previously submitted a bibliography reference document along with an executive

summary of the science that supports the X. We have again included it with this document. The X meets all of the above criterion used to evaluate whether or not a device is Investigational. Workers Compensation Misc will pay for other X. Those X if successful, will be repeated every X. The X is unique, as it is X. The peer-reviewed publications of two and five year follow support this ascertain. It is my position this denial is inconsistent with benefits provided to the patient and for which premiums have been paid. These benefits provide the patient with access to medically necessary procedures, which provide relief of their current symptoms. For reasons set forth above, I believe the denial of the X is unwarranted and unsupported by the patient's current medical status and current peer-reviewed literature. Given the previously submitted history, physical examination and the radiologic findings, the X is medically necessary and supported by strong science. I would like to perform this procedure at X." Per a reconsideration review adverse determination letter dated X by X, MD, the appeal request for X was denied. Rationale: "The Official Disability Guidelines recommend not recommend X. Despite promising early reports, further trials with longer-term outcomes and less risk of bias are required. On X, the claimant was seen for a follow-up visit and reported pain in the low back with radiation down the right anterior thigh to the knee. The claimant reported increased tingling in the anterior thigh with intermittent numbness in the calf and foot. The pain level was X out of X. The claimant trialed X. On exam, X were noted. There was X. Lower extremity reflexes were X. There was decreased sensation to pinprick in the X. There was a X. Lower extremity strength was X. A lumbar MRI dated X revealed the following: Small to X. This report has not significantly changed from the previous study. There was a small X. This had mildly worsened since the previous study. Per the letter of appeal dated X, the patient did not receive adequate relief from X. The claimant had tried and X. This request was previously reviewed and denied as X. While

there is documentation for low back pain, the guideline does not recommend X. Partial certification is not permitted in this jurisdiction without peer-to-peer discussion and agreement. As such, the appeal request for X is noncertified. Thoroughly reviewed provided documentation including provider notes, peer reviews, and imaging X. While the cited ODG criteria generally do not recommend X. Since the X. There is no mention of X on MRI report or provider documentation. Further, the patient has X. BVN ablation is not indicated. X is not medically necessary and non certified

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

X may be helpful in select populations of patients with primarily axial back pain. While the cited ODG criteria generally do not recommend X. There is no mention of X on MRI report or provider documentation. Further, the patient has X. X is not indicated. X is not medically necessary and non certified
Upheld

A 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**
- ☒ **ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**
- ☐ **AHRQ- 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 JUDGMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**
- ☐ **MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**
- ☐ **MILLIMAN CARE GUIDELINES**
- ☐ **PRESLEY REED, THE MEDICAL DISABILITY ADVISOR**
- ☐ **TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS**
- ☐ **TMF SCREENING CRITERIA MANUAL**
- ☐ **PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)**
- ☐ **OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**