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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)

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

INFORMATION PROVIDED TO THE IRO FOR REVIEW: • X

PATIENT CLINICAL HISTORY [SUMMARY]: X who was injured on X. X injured X left leg when pulled into a X. The diagnosis included lumbar radiculitis, bulging lumbar disc, spondylosis of lumbosacral region, constipation due to opioid therapy, above knee amputation of left lower extremity, phantom lib pain and complex regional pain syndrome type 2 of left lower extremity. On X, X was seen by X, FNP-C for follow up after a procedure. X was following up after having X. X had X relief of symptoms. X reported constant relief. At the time the pain was rated X. The last pain medication was taken on X. X required no assistance with daily activities. Regarding lumbar back pain, X reported the symptoms were located in the low back. The pain radiated to the left buttock, left anterior thigh, left posterior thigh, left leg, left lower leg (phantom limb pain) and buttocks. X described the pain as sharp and aching. The pain was described as severe. The pain started in X. The lumbar back pain was precipitated by accident. Symptoms were exacerbated by weight bearing, back motion, standing, sitting, prolonged standing, prolonged sitting, lifting, bending, straining, supine position, walking, lying down and in the morning. Symptoms were relieved by rest. Associated symptoms included leg numbness, leg weakness, back stiffness, leg pain and paravertebral muscle spasms. X had a X. X tried by X included X. Regarding leg pain, X stated the leg pain began suddenly (traumatic injury on X resulting in amputation) and had

been occurring for years. The symptoms have been occurring in a persistent pattern. The symptoms were described as a burning sensation, pain and shooting pain. There was involvement of the left lower extremity (aka stump). There were no precipitating factors. Aggravating factors included exertion. Relief was provided by rest. There have been no previous evaluations. There was a medical history of X. On examination, blood pressure was 138/82 mmHg, weight 230.5 pounds and body mass index (BMI) 33.07 kg/m2. Examination showed X was obese and well developed. X had a X. X stated the X had not provided adequate pain relief. X presented to the emergency room (ER) due to severe pain to left lower extremity. X was treated with X. X complained of constipation with the opioids. X was prescribed. At the time X was in the process of being approved for X, which was initially denied by insurance. X was also requesting X. X was encouraged to continue the process of X. On X, X was seen by X for follow up visit after a procedure. X was following up after having X. X had X relief from the procedure. X had constant relief. The pain at the time was rated X. The last pain medication was taken on X. Regarding lumbar back pain, X reported the symptoms were located in the low back. There was no radiation. X described the pain as sharp and aching. The pain started in X. The lumbar back pain was precipitated by accident. Symptoms were exacerbated by weight bearing, back motion, standing, sitting, prolonged standing, prolonged sitting, lifting, bending, straining, supine position, walking, lying down and in the morning. Symptoms were relieved by rest. Associated symptoms included leg numbness, leg weakness, back stiffness, leg pain and

paravertebral muscle spasms. X had a X. X tried by X included X. Musculoskeletal examination showed X. Left X was recommended. Per a utilization review adverse determination letter dated X by X, MD, the request for X was denied. Rationale: “Based on the evidence-based and peer-reviewed guidelines, X is not recommended as a first-line treatment option due to inconclusive benefit, lack of benefit, or potential harm. Per evidence summary, a worst-case scenario analysis from the randomized controlled trial reported that X of patients with X achieved X or greater pain relief, while X of patients who received X achieved at least X relief at X months. While low-quality evidence supports the effectiveness of X. In this case, the claimant sustained a work-related injury to X left leg on X. As per the report dated X, X had experienced extreme pain since X when X suffered a X of X left leg. Between X and X, X had X. X underwent X, stump revision in X, and right foot surgery in X. However, X continued to endure neuropathic pain which had not improved with X. The claimant was then treated with X. X underwent X on X. The claimant was then treated with X. As per the recent visit on X, the claimant reported current pain level as X. X requires no assistance with daily activities. However, guidelines do not recommend X. Moreover, Guidelines do not support continued focus on pain as it is counterproductive, especially at this point in chronicity with residual disability and deficits. Guidelines support home management for maintenance care. Exceptional factors are not present to support endless treatment or prolonged focus on pain at this point in functional plateau. There is no new Intervening event. Hence, the request

for X is not certified. “An MRI of the lumbar spine dated X showed at X was noted. There was X. X was noted of the X. At X. X was noted of the facets. The report was 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 recommendation, X is not recommended as a first-line treatment option due to inconclusive benefit, lack of benefit, or potential harm. Per evidence summary, a worst-case scenario analysis from the randomized controlled trial reported that X of patients with X achieved X or greater pain relief, while X of patients who received X achieved at least X relief at X months. While low-quality evidence supports the effectiveness of X. In this case, the claimant sustained a work-related injury to X left leg on X. As per the report dated X, X had experienced extreme pain since X when X suffered a X. Between X and X, X had X. X underwent X, stump revision in X, and right foot surgery in X. As per the history and physical note dated X, the claimant underwent X on X. On X, X followed up status X and reported X temporary relief of pain, lasting X hours. On X, the claimant was administered X. On X, the claimant was treated with X. During the follow-up visit on X, the claimant reported X constant relief from the X. On X, the pain level was rated at X on current medications. X tried included X. It was noted that X pain significantly reduced activities of daily living and could reach level of more than X during an exacerbation. X had X. However, guidelines do not recommend X. Moreover, guidelines do not support the continued focus on pain as it is counterproductive, especially at this point in chronicity with residual disability and

deficits. Guidelines support home management for maintenance care. Exceptional factors are not present to support endless treatment or prolonged focus on pain at this point in a functional plateau. Also, there is a previous noncertification of the same request on X. Hence, the request for X is not certified. “An appeal letter was completed by Dr. X on X stating, “Please consider this prior authorization request for the above patient to have a X. Unlike other pain management procedures, the benefit of X to the patient can be assessed from the trial procedure, which is prior to the X. During the trial procedure, X. The trial procedure allows patients to temporarily experience X and the effect it has on controlling their pain, in order to make an informed choice about pursuing X. X has been widely used since the X and is generally considered when the patient has not responded to other treatments. “Per a reconsideration review adverse determination letter dated X by X, MD, the request for X was non certified. Rationale: “Based on the clinical information submitted for this review and using the evidence-based, peer-reviewed guidelines referenced above, this request is not certified. Unable to obtain provider for a peer-to-peer discussion. Regarding X. In this case, on X, the claimant complained of lumbar back pain rated X which radiated into the left buttock, thigh, leg, and lower leg (phantom limb pain), and which was associated with leg numbness and weakness, back stiffness, and paravertebral muscle spasms. The claimant reported that the pain significantly reduced ADLs. Prior treatments included X. The medication list included X. The physical exam of the lumbar spine revealed a X. The diagnoses were lumbosacral radiculitis, chronic pain

disorder, long-term prescription of opiate use, phantom limb pain, complex regional pain syndrome type 2 of left lower extremity, and above-knee amputation of left lower extremity. Per the prior UR dated X, the request for X was non-certified as the guidelines did not recommend X. Per the correspondence dated X, based on the current clinical situation, other potential options for treatment that were considered, and the clinical evidence supporting the use of X, the provider believed this was the best treatment for the claimant at the time and therefore, should be a covered benefit based upon medical necessity. The provider noted that the claimant had X. The claimant had undergone careful screening evaluation and diagnosis by multiple prior physicians. The provider also noted that the X had several distinct advantages for the claimant, had been proven clinically effective, and offered the prospect of enabling chronic pain individuals to return to ADLs and potentially discontinue or reduce the use of X. Based on the records provided, the provider noted that there was failure with prior treatments; however, there was mention of relief with X. Additionally, there is no documentation of the measurable objective functional response with prior treatment to validate failure. Furthermore, the guidelines do not recommend the requested treatment as the evidence shows inconclusive benefit, lack of benefit, or potential harm. Moreover, continued focus on pain, at this level of chronicity is counterproductive. As such, the request cannot be certified. Therefore, the request for X is non-certified.
“Thoroughly reviewed provided documentation including provider notes, imaging results, and peer reviews. Patient with

chronic complex pain issues and has exhausted first-line treatments as well as more interventional procedures to treat X pain. Given prior treatments and continued intractable severe pain, pursuing X is reasonable and within cited ODG criteria noted by 2 peer reviews. X is medically necessary and certified

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

Thoroughly reviewed provided documentation including provider notes, imaging results, and peer reviews. Patient with chronic complex pain issues and has exhausted first-line treatments as well as more interventional procedures to treat X pain. Given prior treatments and continued intractable severe pain, pursuing X is reasonable and within cited ODG criteria noted by 2 peer reviews. X is medically necessary and certified
Overturned

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)**