

**I-Resolutions Inc.**  
**An Independent Review Organization**  
**3616 Far West Blvd Ste 117-501 IR**  
**Austin, TX 78731**  
**Phone: (512) 782-4415**  
**Fax: (512) 790-2280**  
**Email: [@i-resolutions.com](mailto:@i-resolutions.com)**

***Notice of Independent Review Decision***

**IRO REVIEWER REPORT**

**Date: 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 Overturned (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 at work on X, while**

trying to repair a "X." X stated that as X. The diagnosis was mononeuropathy and posttraumatic osteoarthritis of right knee. X, MD evaluated X on X, for right knee pain rated X. The pain was described as sharp, spasms, and tingling. It was better by rest and worsened by activity, inactivity, movement, sitting for long periods, standing for long periods, use, walking for long periods, weather changes. Right knee examination revealed X. The assessment was mononeuropathy and posttraumatic osteoarthritis of right knee. It was noted X continued to have severe knee pain with instability. X was referred by orthopedic Dr. X for further pain management as no further surgical intervention was recommended at the time. X complained of knee pain, exacerbated by prolonged ambulation, standing from sitting, mildly improved with rest, stretches and NSAIDs, X pain, sharp without radiating symptoms, no significant improvement with physical therapy or with medications (completed both for more than X weeks in the past three months). X reported X. X was to continue X as needed, continue the X. A X for the right knee was ordered. Dr. X noted that based on X history and physical exam, X diagnosis was consistent with osteoarthritis and mononeuropathy. Pain continued to be severe, chronic, and debilitating. Pain was on average an X. X had difficulty performing ADLs without experiencing pain. X had X thus far. Dr. X believed X would benefit from a X. If X responded well to the X, X would benefit from X. X had continued over the past X months with X. X was a non-surgical candidate at the time. X attended X psychological evaluation by X, PsyD on X, to determine if X would be a psychologically appropriate candidate for a X. X suffered from right lower extremity pain secondary to a work-related injury. X reported X experienced significant and pain after the injury. X was seen in an X. X participated in X. X underwent a meniscus repair procedure in X and a right knee replacement in X. X continued to experience pain in X right knee which radiated down X right leg, with associated numbness and tingling. Due to X intractable pain and loss of functioning, X physician had recommended a X. It was noted that X presented as a psychologically stable individual who was enduring a clinical medical condition causing chronic pain and resulting physical limitations. X was intelligent, X judgment was sound, and X was capable of making an informed decision at the time concerning the pending surgical procedure. There was no evidence of X. X was appropriate concerning X expectations and understands that X would not make a complete recovery from pain despite a successful X. X understood that X would continue to suffer from some intractable pain despite X

physician's best efforts. X was likely to be compliant with post-surgical care and X was capable of handling the psychological and physical discomfort that accompanied various medical procedures. X did not present as narcotic seeking. The diagnosis was sprain of unspecified site of right knee, initial encounter (X). X was psychologically cleared for the X. Bilateral lower extremity EMG/NCV done on X, demonstrated evidence of a X. Treatment to date included X. Per a utilization review adverse determination letter dated X, the request for X, was denied by X., MD. Rationale for X: "The request is not medically necessary. In this X-year-old claimant, there are ongoing complaints of right knee pain based on the exam notes of X. The psychological consultation notes of X demonstrate ongoing complaints of pain in the right knee. The claimant is status post right total knee arthroplasty on X. Physical examination of the right knee on X demonstrates decreased end range of motion passively and actively. Tenderness to palpation is noted at the medial and lateral joint line. There is a positive Clark's, patellofemoral grind, and Thomas test noted. MRI of the right knee on X discloses moderate knee joint osteoarthritis. Truncation of the medial meniscus is noted. Mild MCL bursitis is noted. There is lateral joint effusion with findings of synovitis. The electrodiagnostic testing of X discloses moderately severe sensorimotor neuropathy. However, in this case guidelines are not met. Per ODG guidelines, X is not recommended as a first-line option; evidence shows inconclusive benefit, lack of benefit, or potential harm. X is not recommended for chronic pain, Guideline criteria have not been met. therefore, X is not medically necessary." Rationale for denial of X: "The request is not medically necessary. As the request for the X is not medically necessary, the X are not medically necessary. Therefore, the X: X is not medically necessary. "In an appeal letter dated X, Dr. X wrote, "I am formally appealing the denial of prior authorization for X. For more than X years, X has suffered from chronic pain symptoms of the right knee. On average X reports an average pain level of X out of X on a numeric scale with X worst pain score in the past month reported as X out of X. X has attempted to alleviate pain with X but pain and functional limitations persist. X has also failed or has not sustained long term benefit from the following X: X, and pain limits normal activities within their daily living, ability to work, ability to fulfill family role, ability to fulfill social role. Due to ongoing and pervasive chronicity of pain and limitation, I requested approval of a X address this condition. X will determine success of the treatment and confirm whether it is in fact medically necessary to X. X offers chronic pain

patients a non-opioid solution to their chronic and debilitating pain when the pain is not responding to other treatments and significantly interferes with their psychosocial wellbeing, ability to function and participate in activities of daily living and overall quality of life. The X is cleared under FDA X. The X used to set patient-specific stimulation programs. The X, are X. The X is adjusted as needed to provide pain relief for the patient. The Centers for Medicare and Medicaid Services (CMS) published a National Coverage Determination (NCD) 160.7: X, which indicates that, "X." In addition to Medicare coverage, many health plans cover X for their members. X has proven clinical evidence, cost effectiveness and society support for use as a treatment for X. • In support of the X, an X was used to X. Patients were followed at X months. The study focused on demonstrating significant long-term pain reduction. The study demonstrated that the. • The American Society of Interventional Pain Physicians (ASIPP) has developed evidence-based guidelines to aid clinicians in safe and effective use of X. These guidelines are built upon a thorough review of existing literature and expert consensus, emphasizing the importance of utilizing both X. This guideline provides a comprehensive review and critical analysis regarding the growing body of evidence supporting the use and long-term efficacy of X in clinical practice. The integration of X, guided by these robust guidelines, holds the potential to greatly improve patient outcomes and promote equitable access to innovative pain management solutions. • A published study, Efficacy of X in Treating Different Pain Targets/Neuralgias concluded, "X has been shown to be safe and effective in treating X. This study is unique in providing long-term follow-up data." Key results show patients had significantly reduced their X use at X months and reported more than X improvement in pain at follow up visits. • X: A Systematic Review of Effectiveness and Safety was published in X concluding "While the vast majority of the reviewed studies were of small samples, collectively they reveal significant improvement in pain utilizing X." There were X studies included in the analysis. • The application of neuromodulation, including X, has been shown to be a cost-effective option in the treatment of X. One study revealed X. The large reduction in healthcare utilization following X. Over X patients have now been involved in various long term clinical studies for craniofacial, knee, shoulder, foot & ankle, and other pain conditions. X has been utilized since the X and has experienced technology advancements through the years. The X is a minimally invasive, non-pharmacologic treatment option for the management of X. In my clinical

judgment, X is the best option for my patient. Please approve X. "Per a reconsideration review adverse determination letter dated X, the appeal request for X, was denied by X, MD. Rationale for denial of X: "ODG by MCG Last review/update date: X "X is not recommended for any of the following X." There are no documented extenuating circumstances to support an exception to the guidelines. The treating provider has not provided strong scientific medical evidence regarding X. The request is not shown to be medically necessary. Therefore, the request for X is upheld and non-certified." Rationale for denial of X: "ODG by MCG Last review/update date: X." There are no documented extenuating circumstances to support an exception to the guidelines. The treating provider has not provided strong scientific medical evidence regarding X. This request is for the X. The request is not shown to be medically necessary. Therefore, the request for X is upheld and non-certified. "Based on the clinical information provided, the request for X is not recommended as medically necessary and the previous denials are upheld. Per a utilization review adverse determination letter dated X, the request for X, was denied by X MD. Rationale for denial of X: "The request is not medically necessary. In this X-year-old claimant, there are ongoing complaints of right knee pain based on the exam notes of X. The psychological consultation notes of X demonstrate ongoing complaints of pain in the right knee. The claimant is status post right total knee arthroplasty on X. Physical examination of the right knee on X demonstrates decreased end range of motion passively and actively. Tenderness to palpation is noted at the X. There is a X noted. MRI of the right knee on X discloses moderate knee joint osteoarthritis. X is noted. X is noted. There is X with findings of X. The electrodiagnostic testing of X discloses moderately X. However, in this case guidelines are not met. Per ODG guidelines, X is not recommended as a first-line option; evidence shows inconclusive benefit, lack of benefit, or potential harm. X is not recommended for X, Guideline criteria have not been met. therefore, X is not medically necessary." Rationale for denial of X: "The request is not medically necessary. As the request for the X is not medically necessary, X are not medically necessary. Therefore, the X is not medically necessary." Per a reconsideration review adverse determination letter dated X, the appeal request for X, was denied by X, MD. Rationale for X: "ODG by MCG Last review/update date: X is not recommended for any of the following X." There are no documented extenuating circumstances to support an exception to the guidelines. The treating provider

has not provided strong scientific medical evidence regarding X. The request is not shown to be medically necessary. Therefore, the request for X is upheld and non-certified.” Rationale for X: “ODG by MCG Last review/update date: X is not recommended for any of the following X.” There are no documented extenuating circumstances to support an exception to the guidelines. The treating provider has not provided strong scientific medical evidence regarding X. This request is for the X that is noncertified above. The request is not shown to be medically necessary. Therefore, the request for X is upheld and non-certified.” There is insufficient information to support a change in determination, and the previous non-certifications are upheld. The patient lost X balance and stepped into a blade and twisted X knee. X underwent right knee meniscus surgery in X and then total knee replacement on X followed by X. The Official Disability Guidelines note that the requested system is not generally recommended as evidence shows inconclusive benefit, lack of benefit or potential harm. It is specifically not recommended for chronic pain. There are no exceptional factors to support the request outside guidelines. Therefore, medical necessity is not established in accordance with current evidence based guidelines. 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:**

Based on the clinical information provided, the request for X is not recommended as medically necessary and the previous denials are upheld. Per a utilization review adverse determination letter dated X, the request for X, was denied by X., MD. Rationale for denial of X: “The request is not medically necessary. In this X-year-old claimant, there are ongoing complaints of right knee pain based on the exam notes of X. The psychological consultation notes of X demonstrate ongoing complaints of pain in the right knee. The claimant is status post right total knee arthroplasty on X. Physical examination of the right knee on X demonstrates decreased end range of motion passively and actively. Tenderness to palpation is noted at the X. There is a X noted. MRI of the right knee on X discloses moderate X. X is noted. X is noted. There is X. The electrodiagnostic testing of X discloses X. However, in this case guidelines are not met. Per ODG guidelines, X is not recommended as a first-line option; evidence

shows inconclusive benefit, lack of benefit, or potential harm. X is not recommended for X, Guideline criteria have not been met. therefore, X is not medically necessary." Rationale for denial of X: "The request is not medically necessary. As the request for the X is not medically necessary, the X are not medically necessary. Therefore, the X: X right knee is not medically necessary." Per a reconsideration review adverse determination letter dated X, the appeal request for X, was denied by X, MD. Rationale for denial of X: "ODG by MCG Last review/update date: X for Pain "X is not recommended for any of the following X." There are no documented extenuating circumstances to support an exception to the guidelines. The treating provider has not provided strong scientific medical evidence regarding X. The request is not shown to be medically necessary. Therefore, the request for X is upheld and non-certified." Rationale for denial of X: "ODG by MCG Last review/update date: X "X is not recommended for any of the following X." There are no documented extenuating circumstances to support an exception to the guidelines. The treating provider has not provided strong scientific medical evidence regarding X. This request is for the X. The request is not shown to be medically necessary. Therefore, the request for X is upheld and non-certified." There is insufficient information to support a change in determination, and the previous non-certifications are upheld. The patient lost X balance and stepped into a blade and twisted X knee. X underwent right knee meniscus surgery in X and then total knee replacement on X followed by X. The Official Disability Guidelines note that the requested system is not generally recommended as evidence shows inconclusive benefit, lack of benefit or potential harm. It is specifically not recommended for X. There are no exceptional factors to support the request outside guidelines. Therefore, medical necessity is not established in accordance with current evidence-based guidelines. 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)**