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***Patient Clinical History (Summary)***

X who was injured on X. X with a X. X was diagnosed with X. The additional diagnoses were X.

On X X was evaluated by X, MD for the X pain. X had received a X on the prior visit without relief. X rated the pain as X. X was taking X. X had a history of X and X. Blood pressure was noted to be X and body mass index X. The examination of the X showed X, and there was X noted. X sign was positive. On X examination, there was X deficiency in X in laterally X in neutral X in extension, X, and X. X examination showed X. The diagnosis was X. Dr. X noted that X had failed X treatment and ordered X.

An MRI of the X dated X revealed a X.

Treatment to date consisted of medications (X), X.

Per a utilization review determination letter dated X, X, MD, documented that the request for X was not medically necessary. It was determined that X had complaints of X pain, and there were no complaints of any mechanical symptoms such as X. There was no mention of any

participation in X, which might help improve X symptoms. Furthermore, there was no official MRI report of the X nor description of the MRI included in progress noted to indicate the presence of a X. Considering the absence of those subjective symptoms, X treatment and objective findings, the request was not medically necessary.

A letter dated X by X, MD indicated that the reconsideration request was non-certified. A previous review stated that X had not participated in X; however, there had been previous participation in X without apparent improvement of X pain. There was also no official MRI report provided at that time. MRI of the X revealed X. There was also findings of X. Additionally, and as stated in the previous review, there were no mechanical symptoms such as X to relate X ongoing symptoms to a X. Guidelines only also support a X in the absence of X. There was significant X noted on X MRI, and performing a X on X might very well increase symptoms and X. As such, the request was not medically necessary.

***Analysis and Explanation of the Decision include Clinical Basis, Findings and Conclusions used to support the decision.***

The ODG supports X which failed to improve with X care. The documentation provided indicates that the injured worker complains of X pain that began after a X. A physical examination of the X documented an X, tenderness, and positive X. Additionally, the injured worker had reduced X. X care included X, without relief. An MRI of the X documented a X. The treating provider has recommended a X given the failure of X treatment. Based on the documentation provided, the ODG would support the requested X as there are obvious mechanical symptoms on physical exam related to the X and a failure of X care. Guidelines do not indicate that X is not possible in the setting of X. Guidelines recommend a failure of X months of X care prior to X in the setting of X. The injured worker has had symptoms in the X for X year despite X care. Given the documentation available, the requested service(s) is considered 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 and Environmental Medicine
- AHRQ-Agency for Healthcare Research and Quality Guidelines
- DWC-Division of Workers Compensation Policies and 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
- ODG-Official Disability Guidelines and Treatment Guidelines
- Pressley Reed, the Medical Disability Advisor
- Texas Guidelines for Chiropractic Quality Assurance and 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)

### **Appeal Information**

You have the right to appeal this IRO decision by requesting a Texas Department of Insurance, Division of Workers' Compensation (Division) Contested Case Hearing (CCH). A Division CCH can be requested by filing a written appeal with the Division's Chief Clerk no later than 20 days after the

date the IRO decision is sent to the appealing party and must be filed in the form and manner required by the Division.

Request for or a Division CCH must be in writing and sent to:  
Chief Clerk of Proceedings Texas Department of Insurance  
Division of Workers' Compensation P. O. Box 17787  
Austin, Texas, 78744

For questions regarding the appeals process, please contact the Chief Clerk of Proceedings at 512-804-4075 or 512- 804-4010. You may also contact the Division Field Office nearest you at 1-800-252-7031.