C-IRO Inc.
An Independent Review Organization
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Description of the service or services in dispute:

X

Description of the qualifications for each physician or other health care provider who reviewed the decision:

Board Certified X

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

X

Information Provided to the IRO for Review

X

Patient Clinical History (Summary)

X is a X who was injured X. X reported that while at X. X was X and X. X started X and was doing the X and X started having X. Diagnoses were other X.

Per a follow-up note dated X with X, DO, X continued to have X. X in the X was also noted. At the time, X was X and X. X pain scores were anywhere from X. It was X and X. X had a X. X had X, X, and X. It was a X. X pain scores were X. A X was recommended to X at X. X was X and X, but realized something needed to be done. It was an excellent avenue in a X approach for X, X and X.

On X, X, DO evaluated X for X. The pain level was X. The quality of pain was X, and X. It was X. X had pain with X, which was X and X. Aggravating factors were X, X or X, X, X, and X. X were X. X reported pain with X, and X. X showed X, pain with X, and X. X and X.

An X dated X showed X, and X. A X dated X demonstrated status X and X. There was X. A X on X revealed X, which X. The X also X. There was a X.

Treatment to date included X.

Per a utilization review adverse determination letter dated X and X, the request for X with X to X was denied by X MD. Rationale: “ODG X online version, X, X, “Recommended as a X. This treatment should be administered in X. Not recommended for treatment of X. X are not recommended as a treatment for X. X at X are not recommended. See specific criteria for use below. Patient criteria for X: X. X must be corroborated by imaging studies and when appropriate, X, unless documented, X, and X support a X. A request for the procedure in a patient with X requires additional documentation of recent symptom X. (2) Initially X. “The X presented with X. There is a request for X. The imaging does not verify X. There is no documentation of X as required by the guidelines. Hence, the request for X is not medically necessary.”

Per an appeal letter dated X, appealed treatment / service request was X between X to X.

Per a utilization review adverse determination letter dated X and X, the reconsideration request for X between X to X was noncertified by X MD. Rationale: “ODG X version X Recommended as a short-term treatment for X, and / or X. This treatment should be administered in X. (1) X causes pain and/or X must be well documented, along with objective X. X must be corroborated by imaging studies and when appropriate, X, unless documented pain, X and X. A request for the procedure in a

patient with X requires additional documentation of recent symptom X. (2) Initially X to X. X is not generally recommended. When required for X, a patient should remain X." “The injured worker reports X, as well as X. X on the X. The injured worker has X and X. Current X – X, X, X, X, X. Previous treatments include X, and X. X indicates the X but currently at X. X per X on X. In this case, the request for the X is medically supported based on the documentation provided. However, there is no documentation of X. X is not medically indicated. As the provider could not be reached to discuss modification, the request cannot be certified. Therefore, the requested X is 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. The patient’s X to establish the presence of a X. X of the X dated X fails to document any significant X. At X there is X. The X are X. At X there is a X which X. the X are X. There is X. The X. At X there is X. The X are X. The X. Therefore, medical necessity is not established in accordance with current evidence based guidelines.

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)