C-IRO Inc.
An Independent Review Organization
3616 Far West Blvd Ste 117-501 CI
Austin, TX 78731
Phone: (512) 772-4390
Fax: (512) 387-2647
Email: @ciro-site.com

Notice of Independent Review Decision

Amended Letter

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:
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 sustained a X on X. The mechanism of the injury was a X. X was X when X and X and X. X was diagnosed with a X, X.

X was seen by X, MD on X and X. On X, X complained of X. X could X, X, and X. The pain was described as X, X, and X. It was rated at X. The X. The symptoms were X by X and X. X denied any X. On examination, X and X. X was X. On X, X presented for continued X. The pain was X, X,

and X. It was rated at X. X stated that the symptoms were X by X. There was X since the prior visit.

An X of the X dated X was X in the X. This probably represented a X, X that had continued some X or X. There was also X on the X. X were noted. There was a X and X in X and X. X and X from the X was noted.

Treatment to date included X, X, and X.

Per an Adverse Determination letter dated X, the request for X on the X, in office with current X and X was denied by X, MD. Rationale: “The Official Disability Guidelines conditionally recommends X on a case-by-case basis as a X for patients with X. X are to determine the X when the diagnosis remains X after a standard evaluation using a clinical / X, X, and X. X may be indicated when evaluation of X, X, and symptoms differ from those X; to X when there is evidence of X; when there is a need to determine a X when clinical findings are consistent with X, X, but imaging studies are inconsistent; or to identify the origin of pain in patients who have had previous X. Official Disability Guidelines recommends X when patients have X. Patients should always remain X enough to converse with the medical provider. This claimant was diagnosed with a X and X. The claimant had an X that was X from a X marked X, probably representing a X, X which had continued some X or X. There was also an X on the X. X with X at X resulting in X. There was a X and X and X. X and X from X. The claimant had completed at X and treatment with X, X, X, and X. The claimant reported X continued to range from X/X and X. The claimant had complaints of X with X. The claimant reported X was able to X, but can X, had X, X, and X in the X the claimant had X, X and-X, X and constant pain to the X and X. The examination revealed X and X and a X. The claimant had a degree of X about X and would require X. However, the request lacked documentation of X of X. Therefore, the request for X is non-certified”.

Per a Utilization Review Decision letter dated X, the prior denial was upheld by X, MD. Rationale: “Regarding the request for X. The Official Disability Guidelines state that X for the diagnosis of X conditions is recommended on a case-by-case basis for claimants with X, to determine the level of X when the diagnosis remains uncertain after standard evaluation using clinical / X, X, and X. To evaluate X were in X and X from those found on imaging, to determine X when there is evidence of X, to determine X when clinical findings are consistent with X, but imaging studies are inconsistent and to identify the origin of pain in claimants who have had previous X. The guidelines indicated to seek further information from the X of the guideline, which states that for a claimant with X there should be additional documentation of recent symptom X associated with a X state. X is generally not recommended. If required for X, the claimant should remain X. In the clinical record submitted for review. There was a lack of documentation of the indications for a X for the diagnosis of X as the diagnosis did not remain uncertain. The X and symptoms did not differ from those found on imaging, there was a lack of documentation of clinical findings were consistent with X, but imaging was inconsistent and there was a lack of documentation that the claimant had previous X that would warrant the request. The X chapter was referenced and there was a lack of documentation of recent symptom X associated with a deterioration of the claimant’s X that would warrant the request. X would be indicated, as the physician documented X towards X. Therefore, the request for X are non-certified”.

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

Based on the medical documentation submitted, X would agree with the previous denials. The requested X-is not supported as medically necessary. The records lack documentation consistent with X or recent symptom X associated with a X of the claimant’s X that would warrant the request. Based on the medical record submitted, medical necessity is not established.

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)