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

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 Overtuned Agree in part/Disagree in part

☐ Upheld Agree

.

INFORMATION PROVIDED TO THE IRO FOR REVIEW: • X

PATIENT CLINICAL HISTORY [SUMMARY]: X who was injured on X. X reported X worked as a X. X experienced immediate pain in X lower back. The diagnoses were chronic lumbar back pain; lumbar facet and ligamentous injury at X; and lumbar disc extrusion with annular tear at X. On X, X was seen by X, DO for a follow-up for injuries to the back. X had a X. At the time, X reported tremendous improvement of the pain and X symptoms for a few days after the procedure. X was very pleased with the results and the outcome. X stated that for about a week, X got excellent relief. X was noticing resurgence of the pain at the time. X continued an X. X continued to take medication as needed. On examination, X weight was 215 pounds. Lumbar spine examination revealed X. X would benefit from a X. An MRI of the lumbar spine dated X showed 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 The ODG by MCG, "Criteria for X. X." The patient was diagnosed with low back pain, unspecified. In this case, the percentage of pain relief after the X is not quantified in the records. The request is not shown to be medically necessary. Therefore, the requested X is denied. "Per a reconsideration review adverse determination letter dated X by X, MD, the request for X was non certified. Rationale: "The Official Disability Guidelines conditionally recommend X. On X , the claimant was seen for a follow up visit and reported excellent relief in pain and symptoms for about a week after X. The claimant was doing an X. The claimant X on X. On the exam, there was X. There was X. There was X. There is X. Lower extremity strength was X bilaterally. X was X. Lumbar MRI dated X noted X. Mild left X at this protrusion at X. Right paracentral superior disc extrusion with X. This request was previously reviewed and denied as X. While there is documentation for low back pain with improvement from X , there is no documentation of X. Also, there is documentation for X at the levels requested. Partial certification is not permitted in this jurisdiction without peer-to-peer discussion and agreement. As such, the request for X is noncertified. "On X, X was seen by Dr. X for a follow-up visit. X reported X underwent X. X was later seen on X and was recommended X. Unfortunately, this had been denied by the worker's comp. Per the ongoing visit's discussion, X was frustrated with the worker's comp denial. X stated X had X resolution of the back pain after the X. X stated that X visual analog score was X

after the X. X subsequently had resurgence of the pain. X stated that the worker's comp denial of the procedure had left X with pain and suffering. X had been unable to do X normal activities. X had been unable to do X normal activities and unable to go to the gym for the exercises X did. X continued to use medication as needed. X denied side effects from the medication. X requested a refill of X medication. On examination, X weight was 215 pounds. Lumbar examination revealed pain with range of motion testing most notable with extension. X had tension in the paraspinal muscles around the X on the right side. The plan was to continue an X. X was encouraged to continue to utilize modalities such as ice, heat, and massage. X were refilled. A right X was recommended. Per a Prospective Review (M2) Response dated X, as noted by the Physician Advisors, during the Adverse and Appeal Determination Denials, per the ODG by MCG, criteria for X for diagnosis of facet joint mediated pain, included documentation of significant visual analog (VAS) score and functional improvement. As also noted by the Physician Advisors during the Adverse and Appeal Determination Denials, X was diagnosed with low back pain, unspecified and in this case, the percentage of pain relief after the prior X was not quantified in the records. Unfortunately, Dr. X was not available for a peer-to-peer discussions during the Adverse and Appeal Determination Denials. Therefore, the suggested X as requested by Dr. X where the ODG criteria had not been met, was not supported and was not medically reasonable or necessary at the time. Thoroughly reviewed provided documentation including provider notes, imaging interpretations, and peer Reviews. Dr. X documented 100% pain relief after procedure in terms of patient's back pain and given successful X, is requesting X, or X at the X level. Documentation meets specified ODG criteria from peer reviews and is standard clinical care, thus requested procedure is indicated. However, no documentation discusses why the patient would need X, thus only the X is warranted. X is medically necessary and certified and the 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:

Thoroughly reviewed provided documentation including provider notes, imaging interpretations, and peer Reviews. Dr. X documented 100% pain relief after

procedure in terms of patient's back pain and given successful X, is requesting X, or X at the X level. Documentation meets specified ODG criteria from peer reviews and is standard clinical care, thus requested procedure is indicated. However, no documentation discusses why the patient would need X, thus only the X is warranted. X is medically necessary and certified and the X is not medically necessary and non certified
Partially 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)**