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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 is a X-year-old X who was injured on X. The mechanism of injury was not provided in given records. The diagnoses were chronic pain syndrome and lumbar radiculopathy.

On X, X was seen by X, MD, for follow up for low back pain. The low back pain was stemming from job-related injuries in X. The pain was in X lower back and running down both legs. X had numbness and tingling in X left leg, and it felt weak. X had an X. X said this lasted about a month. X came back, sent for medication management, reporting worsening of the pain. X had a X. In X, X stated X had back pain and radiating pain down X left hip and leg. X reported left leg numbness and tingling. X stated X had been using ice and stretching to help, but this had been unsuccessful. X also stated X had X stimulator up high, and this was not helping as well. X also reported taking more pain medication because of the pain. X would like to get an X. In X, X weaned X off the X. On X, X was informed that X was no longer on X. Since X had not filled any medicines recently and/or had any procedures, they "X." X had X, so X decided to not take any medicines (prescription or OTC) to control X pain. X did not want any treatments, and a X was "X," so X did not see the point of monitoring X liver. X continued to drink X beers per day. X was a status post (s/p) X and was doing well. X had X. X had a history of radiating lower back pain which is managed with a X. X no longer X from them. On

X, X returned to clinic for follow up. X had chronic pain in the lower back and legs which was well managed, at the time with X. X weaned off X and at the time, just took X. The combination of medications had provided X adequate relief. X presented medication refills on the day. On X, X presented for follow up. X had pain in the lower back and legs. X was taking care of X. X was about to fall, and X tried to keep X from falling, and X reported that may have triggered X pain. However, on that day, X reported that it was not the case, and X was unsure if that was actually what triggered the pain. X reported that X did a home exercise program and continued with home exercise program on a regular basis. X continued with low back pain and left leg. X was also complaining of increasing axial low back pain. On X, X presented for follow-up. X was very frustrated and voiced how upset X was that X appointment was not with Dr. X. They were able to get the X. X came to discuss the results and treatment options. X reported continued low back pain with radiating pain into X left leg. X reported every left step X took, caused a shooting sensation with pain down to X left calf. This pain interfered with X ability to perform ADLs and take care of X. X continued to take X. X continued to participate in home exercises on a regular basis without any improvement in X pain. X no longer had received X. X presented to get an X. At the time, X rated pain as X. The physical examination of the back/spine revealed X. Motor strength was X in all major muscle groups of the lower extremities. There was normal light touch sensation in the lower extremities present. No gross gait disturbance, or use of ambulatory aids was reported. The X dated X revealed there were X. This was most pronounced at X. The CT showed pathology that was most pronounced at X. This pathology was clinically correlated to the pain X was experiencing in X low back with radiation into X left leg down to the calf muscle. Based on X physical assessment and the review of X lumbar CT, X was recommended at the X.

A CT of the lumbar spine dated X revealed X. This was most pronounced

at 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 ODG Low Back guidelines regarding criteria for X, "X." In this case, recent X. Therefore, the request for X is non-certified."

Per a reconsideration review adverse determination letter dated X by X, MD, the request for X was denied. Rationale: "As per ODG guidelines, "Conditionally Recommended X." A peer to peer review was successful with X. The provider had no additional information and didn't know why the patient was not offered X. X was last X. In this case, without X. As such, the request for Appeal request for X is not medically necessary."

Thoroughly reviewed provided records including provider notes, imaging findings, and peer reviews.

Patient with strong history of spine pain issues, some of which may be radicular in nature, for which provider is requesting X. However, imaging findings not demonstrating significant X. Given unclear based on imaging or other studies if X is not warranted. 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 records including provider notes, imaging findings, and peer reviews.

Patient with strong history of spine pain issues, some of which may be radicular in nature, for which provider is requesting X. However, imaging findings not demonstrating significant X. Given unclear based on imaging or other studies if X is not warranted. 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)**