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)

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 who was injured on X. X stated X was working on the third level pick off, and when X had X back turned, X supervisor X. The diagnosis was radiculopathy, site unspecified (X).On X, X was seen in reevaluation by X, MD with respect to a work-related injury sustained while working for X on X . X had been denied X . X reported X pain and stated X was able to do X of the job. Intermittent standing and sitting made the pain worse, stretching made it better. X reported no new symptoms. X was following the treatment plan, which helped a little bit. X had undergone X. X did help significantly, but X had been denied. examination of the X. Flexion, extension, and rotation were decreased by X. Straight leg raise was negative bilaterally and motor was X in both lower extremities. Sensation was grossly intact in both lower extremities. X were noted at X . The assessment was lumbar sprain and strain. Dr. X noted that X had reached a point in X care for X covered work-related injury that related to the X. A successful diagnostic X was previously performed, after which X got greater than X relief with increase in function, decrease in pain, decreased medication intake, and increased mobility of the spine. These met the Official Disability Guidelines criteria for progression to a X. The procedure would be performed under X. An MRI of the lumbar spine dated X done for X. Treatment to date included X. Per a utilization review adverse determination letter dated X, the request for X was denied by X, MD. Rationale: “In this injured worker, the documentation does not support that the low back pain is largely coming from the facet origin. Additionally, there is a lack of substantial documentation to support the response on variable factors required to proceed to X. Finally, this procedure is still considered experimental given conflicting scientific evidence. As such, the requested X is not medically necessary and not according to the medical standard of care. Therefore, the requested X is

non-certified. “Per a reconsideration review adverse determination letter dated X, the appeal request for X. “Although X pain relief was reported after X note shows that the X. Monitored anesthesia care is almost always unnecessary for this X. The request is not shown to be medically necessary. Therefore, the appeal request for X is non-certified. Thoroughly reviewed provided records including imaging findings, provider notes, and peer reviews. Patient had X. Though there is some question that perhaps X. In addition, X is not an experimental procedure but a commonly performed interventional spine procedure with significant evidence to back it up. X is medically necessary and certified

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:

NA

Thoroughly reviewed provided records including imaging findings, provider notes, and peer reviews. Patient had X. Though there is some question that perhaps X. In addition, X is not an experimental procedure but a commonly performed interventional spine procedure with significant evidence to back it up. X medically necessary and certified 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)**