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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. X was involved in a work-related injury when X. The diagnosis was sprain of ligaments of lumbar spine and low back pain.

On X, X, DO, evaluated X for a follow-up visit. X was pleased to report more than X improvement in back, buttock, and leg pain complaints. X continued to work light duty for a X. Dr. X would prefer X to work during normal hours of daylight, which would be better for X pain management and X ultimate recovery. In the meantime, X did continue to feel some stiffness in X back particularly when sitting or standing for prolonged periods of time. X continued to have some X. X also had X. X low back pain was down to X. X was taking X. X had X. X was on X on an as needed basis. Based on the response to care to X prior, Dr. X recommended a X.

On X, X, DO performed X. The preoperative and postoperative diagnoses were X.

On X, X was evaluated by Dr. X for a follow-up. X was advised. X had done well, eliminating X buttock and lower leg pain. X core continued to be weak. X was to continue with X. X was to avoid heavy lifting, bending, or twisting as advised.

An MRI of lumbar spine dated X revealed X. There was X. There was X. There was X. There was 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: “The guidelines conditionally recommend X. X are recommended when there is documentation of sustained improvement of pain or function of \geq X, as measured from X. In this case, the individual noted significant improvement with X. It is noted that the X. The individual was evaluated on X, although there is no documentation of a complaint specific to the lumbar spine. It is not clear if the individual's pain returned after the X, performed on X. There is no documentation of a complaint of X. There is no documentation of an X. It is noted that the individual was able to X. In addition, it is noted that the individual is “X. Based on these factors, the medical necessity for this procedure has not been established. As such, the request is not supported and is denied.

Per a reconsideration / utilization review adverse determination letter dated X by X, DO, the request for X, was denied. Rationale: “Guidelines recommend X. In this case, the most recent notes, from X and X, do not include a physical exam. During discussion, it was stated that the individual was noted to have X on the office visit on. However, there was X. It is noted the individual had a X. Given this lack of documentation, this appeal request is not supported and is denied.

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

As noted by peer reviews, the provider notes recently, and on all follow up notes reviewed, X. In addition, the latest notes do not indicate why another X is 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 results, and peer reviews.

As noted by peer reviews, the provider notes recently, and on all follow up notes reviewed, X. In addition, the latest notes do not indicate why another X is 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)**