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 was X. The diagnoses were lumbar stenosis, lumbar disc extrusion and lumbar radiculopathy following injury at work as an X.

On X, Dr. X was requesting an urgent review for urgent surgery “X” for X given the X.

On X, X was seen by X, MD for evaluation of X ongoing complaints. X reported that X was X. MRI of the lumbar spine along with x-rays demonstrated moderate to X. On examination, X had an X. X did not require an X. X had weakness in X. The surgery of an X was recommended. The surgery was recommended given the size of X. X would need at least X.

X consulted X, NP on X for a follow-up of X. The MRI was with X. It was worse with bending. X wanted to X. Examination revealed deep tendon reflexes X in all four extremities, grips normal / symmetrical, non-focal examination, no tremor, and normal strength, tone, and reflexes. There was full range of motion of the lumbar spine, no bony tenderness, no muscle spasm, and no tenderness in low back muscle. Straight leg raise was X. There was normal range of motion of all joints.

On X, X was seen by X, PA for chief complaint of low back pain. X presented for evaluation of low back pain and right greater than left leg pain that began acutely when X while at work on X. X had been seen by Workman's Comp. X was an X. X job involved frequent lifting, bending, twisting, and climbing. All these duties had been limited secondary to X

pain. X had X. X reported pain across the lumbosacral area with radiation into the buttocks and down the posterior aspect of both legs. X pain was greater on the right side and extended below the knee to involve X calf. This pain was less severe on the left side and involved the back of the thigh but did not extend below the knee. X had not noted any focal weakness. X denied any bladder or bowel dysfunction, no reported saddle anesthesia. X pain was increased with standing, walking, and prolonged sitting as well as bending at the waist and coughing. X reported improvement with lying down and positional changes. X had done X. X had not yet attempted X. Pharmacologic management had included X. The physical examination revealed X. The back showed the range of motion was decreased secondary to pain. There was X strength throughout the X. On assessment, they reviewed the noncontrast MRI of the lumbar spine completed on X at X. This demonstrated X. X had attempted X. They discussed options with regards to other treatments. X would be referred to our Pain Management colleagues for X. If only one X. Given the size of the X. X would likely need an operation at some point. Surgery would likely be an X. The final surgical plan would be determined by Dr. X. X would follow up with Pain Management for X.

An MRI of lumbar spine dated X revealed X. An x-rays of the lumbar spine dated X revealed X was noted.

Treatment to date included X.

Per a utilization review adverse determination letter dated X by X, MD, the request for X was denied. Rationale: “Official Disability Guidelines recommend X. On X, the claimant presented with chief complaints of low back and nerve pain. X has been causing X too much pain. X reports pain across the lumbosacral area with radiation into the buttocks and down the posterior aspect of both legs. On X, the claimant presented with an X. X does not require an X. X has weakness in the X. Lumbar

spine MRI showed X. Lumbar spine x-rays showed X. In this case, there are no documented objective clinical findings of X. Additionally, there is no documentation of a X. As such, the medical necessity has not been established for the Request for X."

On X, X, PA-C and Dr. X wrote an appeal letter for denial of request for X, stating that "Our request was denied due to no objective clinical findings of X. The patient is documented to have X. Objective findings of X. X will be at risk for X. From a surgical team's standpoint, X. With regards to X. X has a X. There are X."

Per a reconsideration review adverse determination letter dated X by X, MD, the request X was denied. Rationale: "Official Disability Guidelines X X. In this case, the request is not medically necessary or appropriate. The submitted medical records do not indicate X. The submitted clinical examination demonstrates limited examination findings which would correlate with the imaging findings. The records also show that the patient was to attempt an X. It is not clear if this X has been performed. As such, the guidelines have not been met. ADDENDUM X: A peer review with the treating provider did occur. The treating provider stated that the X. However, the MRI report demonstrates X. Thus, the requested procedure is not medically necessary as the imaging findings do not correlate. No new information was provided that would warrant the X. Therefore, the requested X remain non-authorized."

Based on the submitted documentation, the requested X is not medically necessary. The imaging report X. The MRI scan does demonstrate X. Additional documentation demonstrates that there are no physical examination findings which would support the requested procedure X. No new information has been provided which would overturn the previous denials. 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:

Based on the submitted documentation, the requested X is not medically necessary. The imaging report does not X. The MRI scan does demonstrate X. Additional documentation demonstrates that there are X. No new information has been provided which would overturn the previous denials. 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)**