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An Independent Review
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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 who was injured on X. X sustained injuries to the left shoulder and left hip during a X. The diagnosis was unilateral primary osteoarthritis, left hip (X).

There are no office visits available in the

provided records. There are no imaging

studies available in the provided records.

Treatment to date included X.

Per a utilization review adverse determination letter dated X, the request for X was denied by X, MD. Rationale: "The requested X is not medically necessary. The submitted medical records do not indicate that the patient has attempted an X. Thus, the guidelines have not been met. Therefore, X, is denied."

Per a reconsideration review adverse determination letter dated X, the request for X was denied by X, DO. Rationale: "The Official Disability Guidelines recommend X. This request was previously noncertified due to X. In this case, the claimant is complaining of acute left hip pain. The assessment showed X. Prior treatments were X. The imaging demonstrated X. The claimant has X. Also, peer review indicated that the imaging results are X is not recommended. Thus, the request for X is noncertified.

Based on the medical records and the prior denials, the claimant does X. Although imaging clearly demonstrates X. The records repeatedly document only X. Given the lack of required X. Therefore, it is this reviewer's opinion that medical necessity has not been established for the services in dispute: X and the prior denials are upheld. 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 medical records and the prior denials, the claimant does X. Although imaging clearly demonstrates X. The records repeatedly document only X. Given the lack of required X. Therefore, it is this reviewer's opinion that medical necessity has not been established for the services in dispute: X and the prior denials are upheld. X is not medically necessary and non-certified.

Non-Certified

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)**