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***Notice of Independent Review Decision  
Amendment X***

**IRO REVIEWER REPORT**

**Date:** X; Amendment 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 a work-related injury, when X was X. The diagnosis was left distal biceps tendon rupture.

On X, X was evaluated by X, PA-C / X, MD, with respect to an alleged work-related injury sustained while working for X. on X. X presented for initial evaluation of the left elbow stating X sustained a work-related injury, when X was X. X was right-hand dominant. X had noticed some decrease in swelling and bruising since the injury. However, X continued to have difficulty with elbow range of motion. X was sent for a CT scan which confirmed X. Examination of the left upper extremity revealed X. X had X. A CT scan of the left elbow from X, revealed a X. The assessment was X. Dr. X noted that in reviewing X history and medical records and examination that day, it appeared that X did sustain an injury to the X. They had a long conversation about X. X had a X sustained secondary to work-related injury on X. The risks, benefits, complications associated with treating X condition were explained to X. The patient has elected to proceed with X. It was recommended X by Dr. X and all other X. X was to continue with X work restrictions per X primary care physician and would follow up with Dr. X for X.

Per a note dated X, a CT scan of the left elbow from X, was reviewed and revealed a 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: "No, the proposed treatment consisting of X is not appropriate and medically necessary for this diagnosis and clinical findings. The Official Disability Guidelines recommend X. The criteria are history of definite X. MRI or ultrasound can be helpful when exam is X. Conservative management is only required for X. Can include X. The claimant is complaining of difficulty with X. The assessment showed X. CT scan revealed X. The claimant met the guidelines' criteria of X. However, the request for "X" is vague. It should be specific to

determine medical necessity. X is not allowed without successful peer review. Thus, the request for X is noncertified.”

Per a reconsideration review adverse determination letter dated X, the appeal request for X was denied by X, DO. Rationale: No, the proposed treatment consisting of X is not appropriate and medically necessary for this diagnosis and clinical findings. The Official Disability Guidelines recommend X. In this case, the claimant reported X. On exam, there was X. There was pain with palpation along the X. There was pain resisted X. Left elbow CT scan done on X revealed X. This request was previously reviewed and denied as the claimant met the guidelines' criteria of X. However, the request for "X" is vague. It should be specific to determine medical necessity. The provider is requesting reconsideration for X; however, the provider failed to provide clarification as to what" X may include. Modification of orders is not supported without peer-to-peer discussion and agreement. As such, the request for X is noncertified.”

The requested X is not medically necessary. The clinical records including examination and imaging findings confirm the presence of a X. However, "X" is vague. The previous denials were correct that a modification to the requested procedure to exclude "X" cannot be done without a peer review. Thus, 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:**

The requested X is not medically necessary. The clinical records including examination and imaging findings confirm the presence of a X. However, "X" is vague. The previous denials were correct that a modification to the requested procedure to exclude "X" cannot be done without a peer review. Thus, 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)**