

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 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, while working as an X. X stated X was X. The diagnoses were neck pain and cervical spinal cord injury with neuropathy.

On X, X was seen by X, MD, for a follow-up visit for discussion of MRI results of cervical spine. X had sustained a X. Initially, X experienced difficulty in ambulating and underwent hospitalization, where X was kept on bedrest for approximately one week before X. Although X regained the ability to walk, X continued to experience chronic, constant pain. X reported persistent pain in X low back radiating to X hips, pain from X neck radiating to X shoulders and down to X elbows, and areas of numbness. The pain interfered with X sleep, forcing X to use multiple pillows and sleep in a specific position to minimize discomfort. At the time, X was on X. X had been referred to pain management for X mid and low back pain; and there were discussions regarding potential X. X had neck pain with radiation to the shoulders and elbows. X had poor sleep due to pain. On physical examination, X walked with a X. X had no gross weakness. Reflexes were absent. X had a mild X. It was noted that X was in a X. X had chronic pain around X shoulder

blades, X back, and X arms. X returned with a cervical spine MRI that showed X. X was a strong surgical candidate for a X. Treatment plan was to proceed with X. An MRI of the cervical spine dated X revealed X. There was X. There was exaggerated X. Treatment to date included X.

Per a utilization review adverse determination letter dated X and a peer review report dated X by X, MD, the request for X, was denied.

Rationale: "The claimant's recent clinical exam findings did not detail evidence of focal neurological deficits in the upper extremities that would correlate with the claimant's most recent imaging report findings to support a X. There is no clear evidence of X. Given these issues which do not meet guideline recommendations, this reviewer cannot recommend certification for the request. Therefore, the request is not medically necessary." Per a reconsideration review adverse

determination letter dated X and a peer review report, dated X by X, MD, the request for X, was denied. Rationale: "ODG by MCG Last review/update date: X "X. Click-through and see related topics field."

ODG by MCG Last review/update date: X "X. ODG Criteria X. Neck or arm pain causing interference with daily function Patient is nonsmoker, has been nicotine-free for X weeks prior to X, or X is required urgently due to X. X. X. Neck or arm pain causing interference with daily function Patient is nonsmoker, has been nicotine-free for X. or surgery is required

urgently due to X." Based on the documentation, insufficient examination findings support the surgical request No examination findings are provided by the treating provider. The record reflects that the patient has participated in X. However, the actual care records indicate therapy for the lumber spine and the left shoulder. It is unclear if the patient has attempted appropriate conservative treatment for the cervical spine. Thus, the guidelines have not been met Therefore, the requested appeal for X is upheld and non-certified."

Thoroughly reviewed submitted documents. No new information was provided to meet the ODG guidelines based on the listed criteria and no prior X for the neck. 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 submitted documents. No new information was provided to meet the ODG guidelines based on the listed criteria and no prior X for the neck. 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)**