CPC Solutions

Phone Number: **(855) 360-1445**

P. O. Box 121144
Arlington, TX 76012

Fax Number: **(817) 385-9607**

Email: @irosolutions.com

A description of the qualifications for each physician or other health care provider who reviewed the decision:

X

Description of the service or services in dispute:

X

Upon Independent review, the reviewer finds that the previous adverse determination / adverse determinations should be:

X

Patient Clinical History (Summary)

The patient is a X whose date of injury is X. The patient was X. Treatment to date includes X. X revealed X and X without evidence of X. There is no X. No X. X at X. MRI of the X revealed X. No X. No X or X. X maintains X. X evaluation dated X. It is reported that the patient made X. Employer has X. Designated doctor evaluation dated X indicates that the patient is at X. The patient was assigned X. The patient has been X. Treatment progress report dated X. The patient continues with X. The patient is noted to be X. Current medications are X. X increased X. X increased from X. Pain Experience Scale X. X from X. X from X. X from X. Response to denial letter dated X indicates that the patient has participated in X. The patient is X. These X. The patient also expressed X. When the X. X is also X.

Analysis and Explanation of the Decision include Clinical Basis, Findings and Conclusions used to support the decision.

Based on the clinical information provided, the request for X is not recommended as medically necessary, and the previous denials are upheld. A prior review non-certified the request noting that there is evidence of X. There was X. The patient has X. There is no evidence that the X. There is no evidence that the X. The patient has X. Exceptional factors are not present. Another review non-certified the request for X could not be validated to X as there were no other X. In addition, it was noted on X that X score in the X. X scored X. On the X. X score on the X. There is insufficient information to support a change in determination, and the previous non-certifications are upheld. The submitted clinical records indicate that the patient has participated in X. The Official Disability Guidelines would support additional sessions only if progress is being made. The submitted X to document significant and sustained improvement as a result of treatment to date. Treatment progress report dated X. X increased from X. X increased from X. X score increased from X. X increased from X. X increased from X and X. Therefore, medical necessity is not established in accordance with current evidence-based guidelines.

A description and the source of the screening criteria or other clinical basis used to make the decision:

- ☐ ACOEM-America College of Occupational and Environmental Medicine um knowledgebase AHRQ-Agency for Healthcare Research and Quality Guidelines
- ☐ DWC-Division of Workers Compensation Policies and Guidelines European Guidelines for Management X
- ☐ Medical Judgment, Clinical Experience, and expertise in accordance with accepted medical standards Mercy Center Consensus Conference Guidelines
- ☐ Milliman Care Guidelines
- ☐ ODG-Official Disability Guidelines and Treatment Guidelines Pressley Reed, the Medical Disability Advisor

Texas Guidelines for Chiropractic Quality Assurance and Practice Parameters TMF Screening Criteria Manual

- ☐ Peer Reviewed Nationally Accepted Médical **Literature** (Provide a description)
- ☐ Other evidence based, scientifically valid, outcome focused guidelines (Provide a description)