

**CPC Solutions**  
**An Independent Review Organization**

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

**P. O. Box 121144**  
**Arlington, 7601**  
**TX 2**

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

***Review Outcome:***

***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

X

***Patient Clinical History (Summary)***

The patient is a X whose date of injury is X. The claimant has a history of X. Claimant X. Claimant reported X. MRI X revealed X. Claimant rates pain X. Pain is located X. Pain is relieved X. X reports X when pain is intense. Claimant X which has improved X pain. However, it is noted that X continues to have X pain. Claimant reports X. Office visit note dated X indicates that the patient X. Office visit note dated X indicates that the patient has a history of X. Shortly after X surgery on X reported X. Pain is rated as X. The patient X. On X examination X. X is within X. X is X on the X. There is X. X is X. X showed X. Progress note dated X indicates that current

medications are X. On X examination there is X. There is X.X. X test is X. X is X. There is X. X are X. X is X. X are X. X is intact in the X. This note states that a X was obtained on X which shows X. No significant recurrent X. Moderate left foraminal stenosis is suggested 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, X is not recommended as medically necessary, and the previous denials are upheld. The initial request was non-certified noting that the claimant has already had a X. The progress note dated X states that this is "X." There was also a subsequent X. It is unclear why a X would also be needed X. Considering the studies already performed, this request is not medically necessary. The denial was upheld on appeal noting that no additional information was provided to address the issues raised by the initial denial. It is unclear how X. There is no documentation of a significant change in clinical presentation to support updated imaging at this time. Therefore, medical necessity is not established in accordance with current evidence-based guidelines. Recommend upholding prior denials. The submitted clinical records indicate that the patient X. The patient underwent a X. There is no clear rationale provided to support additional imaging at this time. The submitted clinical records fail to establish that this patient presents with a condition for which guidelines would support X. Additionally, it is unclear what X the patient has completed to date. Recommend non-certification.

***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 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
- 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)