CPC Solutions
An Independent Review Organization
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Notice of Independent CPC Review Decision

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

Information Provided to the IRO for Review:

X

Patient Clinical History (Summary)

The patient is a X whose date of injury is X. The patient X. Office visit note dated X indicates that the patient presents with X. Current X are X. Pain is rated as X at its worst. The patient has had X and X. Diagnoses at this time have been debated, given X, but not full criteria. Pain is X and X. X does not endorse X, X or X. X continues with X as a result of X and X. X was recommended for X. Progress note dated X indicates that X. X notes X. Pain is rated X. X was discussed for X. X would like to proceed with this. On exam there is X. Assessment notes X, X, X and X. On X, a letter of appeal was submitted that stated the X system was requested due to it being the only X that had demonstrated X. It was noted that X. A X. The X is X. The provider noted that X. The patient was noted to have X. The

patient had X. The pain was noted to X. X had been attempted and had not provided X. Treatment had included X. The provider stated that without the approval of this X the only other options are X, and they would like to X without relying on X. Office visit note dated X indicates that pain is X. Exam of the X notes 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. The denial was upheld on appeal noting that Official Disability Guidelines do not recommend the use of X for patients with X. A prior denial of this request was made due to guidelines not supporting this modality, there were no exceptional factors noted, and medical necessity was not noted. A letter of appeal was submitted that stated the patient had X. The patient has had X. The guidelines do not recommend the use of X for patients with X. therefore, the current request does not meet guidelines recommendations. There is insufficient information to support a change in determination, and the previous non-certifications are upheld. The Official Disability Guidelines note that X is generally not recommended. There is a lack of any high quality evidence to prove X. There is no documentation of X. There are limited objective findings documented on physical examination. Therefore, medical necessity is not established in accordance with current evidence based guidelines.

ODG

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 Internal 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)