

# CPC Solutions

An Independent Review Organization

Phone Number:  
(855) 360-1445

P. O. Box 121144  
Arlington, TX 76012  
Email: @irosolutions.com

Fax Number:  
(817) 385-9607

## Notice of Independent Review Decision

**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's X began after a X with a X. The patient was diagnosed with X, X, and other X. Treatment to date includes X, X, X and X. Per reviewed records, this patient sustained an injury on X and was diagnosed with X, X, and other X. X dated X shows at X the X to X with X. X than X with X and X. At X, there is X with X. X without X. A visit note dated X by X, NP/X, MD, notes complaints of X, X and X. The current pain is rated at X. There are X of X as well as X. Patient has X, X and X, X, X, X, X, X and X. Previous treatments include X, X, X and X. X is gradually X since the last evaluation. Symptoms X in the X than the X, X than the X. The X examination notes X, X. X without X or X. Examination of the X reveals X, X, X or X. The X examination note X in the X, X, X and X. X, X, X, and X is X. X test is X. X are X and X and X with X. The X examination notes X to the X, X, X and X. X is X in all X, X. X is noted to have X with X at X. Diagnosis includes X with X. Current X are X and 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 at the X; X or X and X by on-call X is not recommended as medically necessary and the previous denials are upheld. The previous denial notes that, "The request for X at X is not recommended per ODG. ODG recommends X not above X. In addition, X is not recommended. Medical necessity is not established. Therefore, the request for an X; X or X and X by On-Call X is non-certified and upheld." Appeal denial notes, "ODG by mcg states "Conditionally recommended at a level X on a case-by-case basis as a X for X, X, and/or X that results in X(defined as X to a X that typically causes X, X, and/or X in the part of the X that is supplied with the X from that X), when used in X with X efforts. X is not recommended. Not routinely recommended for determining X during a procedure such as X. X is not generally recommended. When required for X, a patient should X." ODG by mcg regarding X states "X may be recommended when X/X suggests significantly X of the X, and X beyond available X or X is required."

Based on the documentation provided and per the guidelines, the requested X is not considered medically necessary in this case. Guidelines do not recommend the X in the X since there have not been X enough studies to support efficacy and safety. There is no indication to X from guideline recommendations noted. Additionally since the procedure is not recommended neither is X and X is not supported. Therefore, this request is not certified." 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 not recommended in the X. X is not recommended X. Additionally, guidelines note that X is not routinely recommended for determining X during a procedure such as X. X may be recommended when X/X history suggests significantly X of the X, and X of X beyond available X or X is required. 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 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)

