

CPC Solutions
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Notice of Independent 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 was X. X dated X indicates that the patient X. X is X and X is X. X on X was X. Preauthorization request dated X indicates that the patient is X. X improved from X. X improved from X. Use of X decreased from X. X can demonstrate further progress. Preauthorization request dated X indicates that the patient requires the medical services that are only available in a X in order to address the 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 initial request was non-certified noting that, "Per ODG Evidence-Based

Medical Treatment Guidelines, X (Updated X) states, "Total treatment duration should generally not exceed X. (1) If treatment duration more than X is required, a clear rationale for the specified extension and reasonable goals to be achieved should be provided. Longer durations require individualized care plans explaining why improvements cannot be achieved without an extension as well as evidence of documented improved outcomes from the facility (particularly in terms of the specific outcomes that are to be addressed)." Within the medical information available for review, there is documentation of subjective findings (X), objective improvement (X), and conservative treatment (X). However, there is no documentation of a clear rationale for the specified extension and reasonable goals to be achieved, an individualized care plan explaining why improvements cannot be achieved without an extension, as well as evidence of documented improved outcomes from the facility (particularly in terms of the specific outcomes that are to be addressed). Therefore, the requested X is not medically necessary." An additional request was non-certified noting that, "Though the claimant has a history of X secondary to X, it was noted that the claimant had X. The requested X is more than guideline recommendation. As such the request is not considered medically necessary in this case. Therefore, the request for X, is not medically necessary." There is insufficient information to support a change in determination, and the previous non-certifications are upheld. The patient has X to date. The Official Disability Guidelines note that Total treatment duration should generally not exceed X. When treatment duration and/or number of visits exceeds the guidelines, exceptional factors should be noted. There are no exceptional factors of delayed recovery documented. There are no X progress notes submitted for review with documentation of ongoing significant and sustained improvement. Therefore, medical necessity is not established in accordance with current evidence based guidelines.

ODG by MCG (X), Evidence-Based Medical Treatment Guidelines, X Section, X, updated X
ODG Criteria

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)