CPC Solutions
An Independent Review Organization
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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:

☑ Upheld (Agree)

☐ Overturned (Disagree)

☐ Partially Overturned (Agree in part / Disagree in part)

Information Provided to the IRO for Review:

X

Patient Clinical History (Summary)

The patient is a X whose date of injury is X. X grabbed a x. MRI lumbar spine dated X shows at X. The patient has been treated conservatively with a course of X. Follow up note dated X indicates that low back pain is X at rest and X active. X is not taking any current medications. On exam lumbar range of motion is X. X are normal. X is normal. X is normal. X is negative bilaterally. X is normal. Diagnosis: radiculopathy lumbar region and other intervertebral disc displacement lumbar region. Office visit note dated X indicates that low back pain radiates into the left lower extremity. The patient is not working. X on the left. Motor is X bilateral lower extremities. X are intact. X is positive on the left.

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 denied noting that there is no documented evidence of neurological deficits with radiculopathy on physical examination. The denial was upheld on appeal noting that the injured worker has minimal pain rated X out of X. Objective evidence of recent symptom worsening associated with deterioration of neurologic state was not identified. There is insufficient information to support a change in determination, and the previous non-certifications are upheld. The submitted physical examination fails to establish the presence of active radiculopathy. There is no documentation of a X. X is X bilateral lower extremities. X are intact and X is intact. 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)