CPC Solutions
An Independent Review Organization
P. O. Box 121144*Phone Number:* *Fax Number:*
Arlington, TX 76012(855) 360-1445 (817) 385-9607
Email: @irosolutions.com

Notice of Independent Review Decision

Amended Date: X

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. The mechanism of injury is X. The X right hand and shoulder. Note dated X indicates that the patient reports having a history of X. X cervical spine dated X. X. No X. X right shoulder dated X shows X. There is X. No evidence of X. There is a X. Office visit note dated X indicates that assessment is right hand X and X of right X. Progress report dated X indicates that pain is X. X have not provided any improvement. On physical examination X has pain in the right X. X of the cervical spine is X. Progress report dated X indicates that X presents with neck and right upper extremity injury. X still complains of X in the right hand. X is working X. Therapy has been done. Home exercise program did not help. A X was done the previous week and did not help. On physical examination 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 recommended as medically necessary and the previous denials are overturned. The initial request was non-certified noting that the injured worker has a history of neck pain that has an underlying radicular component which guidelines do not recommend the requested procedure. The denial was upheld on appeal noting that there are radicular symptoms as noted by X.

Updated records have been reviewed. The patient's physical examination establishes the presence of X. Cervical X is X. The patient has X. X has failed to improve despite X. Recommend certification of the request.

ODG by X

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Case Number: X ***Date of Notice:*** X

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

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Case Number: X ***Date of Notice:*** X

☐ 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 Medical **Literature** (Provide a description)

☐ Other evidence based, scientifically valid, outcome focused guidelines (Provide a description)