CPC Solutions

An Independent Review Organization

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Notice of Independent Review Decision

Amended Date:

Patient Name: ***Case Number:***

Review Type: X ***Date of Notice:***

Coverage Type: X ***IRO Certification No.:***

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 claimant is a X who sustained an injury on X when X twisted the right X causing pain and swelling. The claimant had used a X brace. The claimant did report tenderness to palpation at the joint line with mechanical catching of the right X. The claimant had been prescribed X and underwent a X with partial improvement in symptoms. No X therapy records were included for review. The initial radiographs of the right X noted joint X. The right X report dated X noted a X. The X evaluation noted continuing right X pain. The physical exam noted painful X at X of the right X. The proposed right X partial X was denied by utilization review as rehabilitation course was not discussed. There was no location of X reported. There was also do detail regarding mechanical symptoms.

Analysis and Explanation of the Decision include Clinical Basis, Findings and Conclusions used to support the decision.

In review of the clinical findings, there is evidence of a X at the right

X. The claimant described X at the right X with X. The current physical exam noted a X at the right X. The claimant had not improved with X, X, or X. It is unlikely that the claimant's symptoms would improve further with X therapy given the mechanical findings. Therefore, it would be reasonable to proceed with X as recommended by the treating provider. Therefore, it is this reviewer's opinion that the requested outpatient X for X is medically necessary and the prior denials are overturned.

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)