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 claimant is a X who sustained an injury on X due to X. The claimant suffered X. The claimant was status post skin grafts with adjacent tissue transfer of the right hand. The claimant had undergone X to the face, both hands, chest, the right lower extremity, and the left thigh through X of X. The last therapy report noted the claimant was tolerating treatments well. A more recent evaluation of the claimant was not included for review.

The X requested were denied by utilization review as there was no indication of significant previous benefit with this treatment or indications to continue with repeat therapies

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

The claimant had continued with X to the face, both hands, chest, the right lower extremity, and the left thigh through X of X. The treatment records noted that the claimant tolerated the treatments well. Specific response to the X was not detailed as of the last therapy report in X of X. The X letter of medical necessity noted that the claimant had continuing issues with X. However, the records did not include a recent evaluation of the claimant detailing these continuing issues. The letter also did not detail the specific response to prior X to include functional improvement. Therefore, it is this reviewer's opinion that medical necessity for the request has not been established and the prior denials are upheld

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 Medical **Literature** (Provide a description)

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