

**CPC Solutions**  
**An Independent Review Organization**  
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**Fax Number:**  
**(817) 385-9607**

***Notice of Independent Review Decision***

**Case Number:**  
**Notice:** X

**X Date of**

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***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

## *CPC Solutions*

### *Notice of Independent Review Decision*

*Case Number:*  
*Notice:*        X

X *Date of*

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#### ***Patient Clinical History (Summary)***

The patient is a X whose date of injury is X. X was working at a X. X. X. X had a X. Treatment to date includes medication management, home exercise program, occipital nerve blocks, massage therapy, physical therapy and a chronic pain management program. Office visit note dated X indicates that the patient presented with X. X did not document whether X could do X regular duties. X was only occasionally feeling the pain. X was on a treatment plan, which was helping. X stated that the X helped significantly. X had greater than X relief. X denied X; however, X had multiple imaging studies. On examination, X of the cervical spine was within X limits.

#### ***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 Official Disability Guidelines, X is conditionally recommended for X. The claimant presented with X and noted pain occasionally. X denied X; however, X had multiple imaging studies. On examination, X of the cervical spine was within X limits. The treatment to date consisted of medications X. There is a lack of documentation of significant and sustained improvement because of prior physical therapy. At X last physical therapy session on X, X reported no relief of symptoms. The most recent office visit note submitted for review indicates that X of the cervical spine is within X limits. No additional exam

findings were noted. Based on the clinical findings the request for X is not medically necessary.” The denial was upheld on appeal noting that, “This is a chronic injury more than X. This claimant would be anticipated to have transitioned by this time to an independent active home rehabilitation program. A rationale or indication at this time for X as opposed to X is not apparent.” There is insufficient information to support a change in determination, and the previous non-certifications are upheld. The request for 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 do not appear to be any contraindications to X. 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 Medical **Literature** (Provide a description)

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