CPC Solutions
An Independent Review Organization
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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. X fell off a broken chair with X neck torquing into X left shoulder. X reported that X injured X left shoulder, left arm and lower back. History and physical dated X indicates that X had X. A follow up note dated X indicates that X is complaining of pain in X left mid scapular area and upper back. X has begun X. X attended X. A follow up note dated X indicates that X was recently hospitalized for a long time due to pain and swelling and inflammation of X left foot and ankle and inability to walk. A follow up note dated X indicates that X is requesting surgery for X left shoulder. Designated doctor evaluation dated X indicates diagnosis is strain of left shoulder and strain of lower back. The patient was determined to have reached maximum medical improvement as of X. Initial pain evaluation dated X indicates that X has tried X. MRI cervical spine dated X shows no convincing abnormal signal in the cervical cord. At X there is a X. This mildly indents the ventral margin of the cervical cord. The central spinal canal measures approximately X. Mild right facet joint degenerative arthropathy. No significant foraminal narrowing. At X there is minimal posterior disc bulge. The central spinal canal measures approximately X. No significant foraminal narrowing. At X there is a posterior disc protrusion centrally and toward the right measuring approximately X. This contacts and mildly flattens the cervical cord. The central spinal canal measures approximately X. No significant facet joint arthropathy or foraminal narrowing. X there is a diffuse disc bulge posteriorly measuring up to approximately X. There is X. The central spinal canal measures approximately X. Mild flattening of the ventral margin of the cervical cord. Moderate to severe bilateral foraminal narrowing. At X there is a central to right paracentral small disc extrusion measuring X. The central spinal canal measures approximately X. Slight indentation of the ventral margin of the cervical cord. A follow up note dated X indicates that X had mid-cervical interspinous tenderness, pain with flexion and coughing and sneezing, exacerbating this pain consistent with cervical disc disruption. A follow up note dated X indicates that X has persistent neck, shoulder, and arm pain. X has decreased neck range of motion, marked mid-cervical interspinous tenderness, numbness in the X. A follow up note dated X indicates that the patient continues with moderate neck, shoulder, and arm pain. X is recommended for X. This is a transitional level. X has numbness in the inner aspect of X arm in the X. X has decreased range of motion in the thoracic spin with an extrusion noted at the X. X is getting fair to good relief with X. Due to X.

Analysis and Explanation of the Decision include Clinical Basis, Findings and Conclusions used

x

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 request was non-certified noting that, “Per ODG, "X is NOT recommended for any of the following...Use of general anesthesia, moderate or deep sedation, or monitored anesthesia care. " In this case, X is planned with X. Although radicular pain is noted with numbness at the X. Moreover, the distribution of pain is unclear and not noted to specifically correspond to radiculopathy involving the X. The request is not shown to be medically necessary. Therefore, the request for X is upheld.” There is insufficient information to support a change in determination, and the previous non-certification is upheld. It is unclear what conservative treatment the patient has received specifically for the cervical/thoracic spine. Prior physical therapy visits appear to be targeted at the lumbar spine and left shoulder. Work conditioning also focused on the low back and left shoulder. Designated doctor evaluation dated X indicates diagnosis is strain of left shoulder and strain of lower back. The patient was determined to have reached maximum medical improvement as of X. A follow up note dated X indicates that impression is left shoulder and lumbar strain. This note then states that X has reached maximum medical improvement. 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:
x

☐ 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)