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
CPC Solutions

Notice of Independent Review Decision

Amended Date: **X**

Case Number: X *Date of Notice:* 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 claimant is a X who sustained an injury on X during a motor vehicle accident. The claimant reported complaints of neck pain which had not improved with prior physical therapy or use of pain medications. The claimant had undergone X. Medications had included X. The X cervical MRI report noted a X. No other significant X. The X evaluation noted continuing neck pain without any radiating pain into the upper extremities. The physical exam noted X. There was a X noted. There was X. X was noted. The proposed X was denied as there were insufficient objective findings on imaging or by physical exam to support the X requests. The request also did not specify the target level for the procedure.

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

In review of the clinical findings, the claimant presented with ongoing complaints of neck pain without specific radicular

complaints. The claimant's physical exam did note X. Review of imaging reports detailed X. The claimant had not improved with previous X. The current evidence based guidelines do not recommend X. However, the records provided did not specify a target level for the proposed X. Further, there were no clear indications to proceed with X based on the imaging findings. Therefore, it is this reviewer's opinion that medical necessity for the X is not 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)

