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 patient is a X whose date of injury is X. X fell onto X back and buttock area. Designated doctor evaluation dated X indicates that X had X. Physical therapy note dated X indicates that the patient presented for X. X did some physical therapy for a few months without success. X is working full-time. On physical examination hip strength was X with flexion and X with abduction. Hip flexion was X, internal rotation X, and external rotation X. Lower extremity sensation intact, deep tendon reflexes intact, there was X. The claimant had limited examination due to a thorough subjective examination and decreased tolerance activity due to high levels of pain and irritability. Rehabilitation potential was fair given the chronicity of issues. The patient was diagnosed with contusion of thorax, unspecified, initial encounter; other low back pain; and unspecified fracture of sacrum, initial encounter for closed fracture.

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

The request for X is not recommended as medically necessary and the previous denials are upheld. The initial request was non-certified noting that, "In this case, the clinical summary states that prior treatments include X. It is recommended that therapy should be X. In this case, it is unclear what extraordinary circumstances exist in which it would be necessary for the claimant to have X. It is unclear why the claimant cannot be X." The denial was upheld on appeal noting that, "In this case, a prior review noted X. There is X. The request is not shown to be medically necessary. As such, the requested X, is non-certified and is denied." There is insufficient information to support a change in determination, and the previous non-certifications are upheld. The submitted clinical records document completion of X. The request for X. When treatment duration and/or number of visits exceeds the guidelines, X should be noted. There are X documented. There are X records submitted for review with documentation of progress. Therefore, medical necessity is not established in accordance with current evidence-based guidelines.

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Case Number: ***Date of Notice:***

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)