

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

X

X

Patient Clinical History (Summary)

The patient is a X whose date of injury is X. The claimant reports that a X. X was X. Diagnosis: X Sprain of ligaments of cervical spine, initial encounter; X Strain of muscle(s) and tendon(s) of the rotator cuff of left shoulder, initial encounter; X Pain in thoracic spine; X Low back pain. MRI of the thoracic spine dated X revealed X. Compression fracture was seen at X, with X loss of X height and X loss of height at X. Note dated X indicates that the patient has done well over a year ago with X. X is back to work full time. The patient underwent X on X. The pre-operative and post-operative diagnoses include chronic thoracic back pain syndrome with herniated disc and disc disruptions at X and X. The claimant tolerated the procedure well and experienced excellent pain relief X minutes after the procedure and was discharged in good condition. Note dated X indicates that X has done well in the past with X. X is reporting some spasms at the X. The follow up note dated X indicates that the patient reported X months of alleviated pain after a X. The claimant states that X pain is now back up to a 6-7/10. The pain is made

worse by coughing and sneezing. Upon physical examination, there is tenderness at the X. Pertinent medications include X. Treatment to date includes X. Note dated X indicates the patient continues with severe axial back pain. X has exquisite tenderness.

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 claimant reported X months of alleviated pain after a X. The claimant states that X pain is now back up to a X. Upon physical examination, there is tenderness at the X. However, the thoracic spine MRI is over X years old and revealed X. Additionally, X, the request is not shown to be medically necessary. Therefore, the request for X is not certified.” The denial was upheld on appeal noting that, “In this case, the provider has not provided sufficient documentation to support this request. Per the X encounter, there was insufficient evidence of radiculopathy as there was no documentation of any focal neurological deficit. Moreover, a thoracic MRI is more than X years old and does not demonstrate any evidence of X. Guidelines and standard practice require X. A prior request for

X was non-certified on X by X, MD. The provider has not provided any new clinical findings or compelling information to support overturning the prior non-certification. Therefore, based on the lack of guideline support and lack of sufficient documentation to support this request, the request is recommended non-certified.” There is insufficient information to support a change in determination, and the previous non-certifications are upheld. The Official Disability Guidelines require X. The submitted physical examination fails to establish the presence of active radiculopathy. The submitted thoracic MRI is from X. There are no updated diagnostic studies/electrodiagnostic results submitted for review. The prior MRI does not show any significant X. There are no objective measures of improvement following 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:

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- 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)