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. The patient was X. X was diagnosed with chronic right wrist and arm pain associated with swelling, hyperesthesia, and allodynia following a traumatic work injury, consistent with complex regional pain syndrome (CRPS) stage I-II. MRI of the right hand dated X shows X. X was noted. X was noted. The patient received a X on X. Follow up note dated X indicates that the X. Follow up note dated X indicates that X has clear example of X. X reports numbness and tingling in X hands following recent X. X has a better than X. X did extremely well follow the X. Follow up note dated X indicates that the patient reports X has helped X with more than X pain relief, improved function, improved range of motion, and decreased use of medication. X can perform activities of daily living at home. X can lift things. X right hand and arm are swollen again. X now has decreased grip strength. X has pain with passive range of motion and light touch. They are requesting X. X have decreased. Active range of motion exercises were advised.

Per a utilization review adverse determination letter dated X, the request for X was denied by X, MD. Rationale: “Regarding X, the Official Disability Guidelines X. It may be indicated when the following criteria are met such as X. Additionally, the procedure is performed X. Per submitted documentation, the request is not warranted. A prior review on file for X was non-certified because the guidelines X. The referenced guidelines recommend that X. According to the guideline, this procedure may only be considered after X. It should also be performed under X. Based on the injured worker’s clinical findings of X, the request is not supported by the guideline recommendation. Since the injured worker X, the request is not medically necessary to treat the current condition. Therefore, the prospective request for X is noncertified.”

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

Per a reconsideration review adverse determination letter dated X, the request for X was denied by X, MD. Rationale: "X, the Official Disability Guidelines X. It may be indicated when the following criteria are met such as X. Additionally, the procedure is performed X. After the review of the submitted documentation, it appears the prior non-certification was appropriate. The referenced guidelines state that X is not recommended as a X. It may be indicated when the following criteria are met such as X. Additionally, the procedure is performed under X. Although the injured worker had symptoms chronic regional pain syndrome in the upper extremity, the request is not recommended by the guidelines due to X. Therefore, the appeal requests for X is non-certified."

Treatment to date included X.

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 recommended as medically necessary and the previous denials are overturned. Guidelines note that X. The submitted clinical records indicate that the patient received the X on X. Follow up note dated X indicates that the X. Follow up note dated X indicates that the patient reports X. X can perform activities of daily living at home. X can lift things. X right hand and arm are swollen again. X now has decreased grip strength. X has pain with passive range of motion and light touch. X have decreased. Active range of

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motion exercises were advised. Given the patient's response to the X is certified.

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

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☐ 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)