

**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 X. X was diagnosed with pain in the unspecified joint, sacroiliitis, and other intervertebral disc displacement in the lumbosacral region. Treatment to date includes X. The most X was on X. Follow up note dated X indicates that the patient is able to X. Progress report dated X indicates that the patient presented for a follow-up visit for the X. The injured workers had done well over the years X. They were back to work; however, over the last X, they reported an increased X. They denied any side effects or complications. They were on X, unable for this X. On examination, they had X. They had some pain in the X. Note dated X indicates that X. X has X. X has a 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 not recommended as medically necessary and the previous denials are upheld. The initial request was non-certified noting that, “Per the submitted documentation, the request for X is not warranted. The referenced guidelines did not

recommend X. Moreover, X are usually performed with X. The cited guideline states that X. Under review X, dated X, the request for X was certified to help relieve left hip and buttock pain and improve joint function. In this case, the injured worker complained of increased left hip and buttock pain because of a work-related X. The pain was associated with X. They were diagnosed with sacroiliitis and other intervertebral disc displacement in the lumbosacral region, which were treated with X. Although the injured worker X. Furthermore, the studies demonstrated functional improvement, decreasing functional benefit after X-month follow-up despite pain improvement. Hence, the medical necessity of the request was not established. Therefore, the prospective request for X is non-certified.” The denial was upheld on appeal noting that, “After the review of the submitted documentation, it appears that the prior non-certification was appropriate. The cited guideline does not recommend X.

However, X. In this case, the injured worker had X. They also had X. However, the general guideline only recommends X. There was no extenuating factor that would necessitate X. Although the X is medically necessary to reduce pain and improve functionality, it cannot be authorized as the request cannot be modified as per this state’s jurisdiction. Jurisdictional regulations do not permit modifications of requests without the consent of the requesting provider. Therefore, the appeal request for X not medically necessary.” There is insufficient information to support a change in determination, and the previous non-certifications are upheld. While the submitted clinical records indicate that the patient has undergone X. The request also includes X, which

is not supported by guidelines and there are no exceptional factors to support the request outside guidelines. There is no documentation about 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:***

- 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)