

**CPC Solutions**  
**An Independent Review Organization**  
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***Notice of Independent Review Decision***

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***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

**Notice of Independent Review Decision**

**Case Number:**  
**Notice:** X

**X Date of**

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**Patient Clinical History (Summary)**

The patient is a X whose date of injury is X. The patient X. Office visit note dated X indicates that X presents with mid and low back pain. X was diagnosed with strain of neck, lower back and sprain of bilateral wrists. Treatment to date includes X. X was seen at X on X for follow up for back pain of the mid and lower back. On exam it was reported that there was paraspinal tenderness. X was now reporting bilateral radicular pain that went to the back of X knees. There were no lower extremity strength deficits. There were no lower extremity sensory deficits. There was no upper extremity sensory or motor deficits. The diagnosis included sprain of the left and right wrist, strain of the lower back, and strain of the neck. X were going to be ordered. Note dated X indicates that X reported there was no improvement in the cervical or lumbar pain. On examinations there were no sensory or motor deficits in the upper or lower extremities. It is reported that there was paraspinal cervical tenderness, tenderness of the thoracic muscles and tenderness of the lumbar muscles. X of the spine were ordered.

**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, "First of all, according to what is well documented throughout the clinical literature, there would be no expectation that this mechanism of injury would result in any discal pathology. Additionally, the individual does not have any documentation of dermatomal specific symptoms with corresponding sensory or motor deficits.

Therefore, there would be no indication to obtain an X. I would consider this unnecessary medical testing. The request for X would not be supported by the Official Disability Guidelines. The denial was upheld on appeal noting that, "The patient sustained multiple injuries after X. Initial evaluations revealed muscle strains in the neck and lower back, bilateral wrist sprains, and a prior scapholunate ligament repair in the left wrist. Despite X, the patient reported ongoing pain in multiple areas, including new complaints of burning pain and tingling in the hands and feet. X-rays of the left wrist were negative, but X of the X were requested for further evaluation. There is X. Additionally, on X, the treating provider documented that the patient was X. This can be categorized as superficial and non-anatomic tenderness, axial loading and acetabular rotation simulation within the first X degrees, distraction with inconsistent straight leg raise, regional sensory disturbance and weakness in a non-dermatomal pattern, and overreaction or out of proportion to mechanism. Documentation of a X suggests even greater than X percent likelihood of not reliably identifying a specific underlying condition, consistent with the patient's mild mechanism of injury. There is insufficient information to support a change in determination, and the previous non-certifications are upheld. The patient

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X. There are no red flag findings on physical examination to support performance of X . On examinations there were no sensory or motor deficits in the upper or lower extremities. There were X documented in 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)