CPC Solutions
An Independent Review Organization
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Notice of Independent Review Decision

Case Number: **X** ***Date of Notice:*** 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 involved in a X. The patient is diagnosed with rheumatoid arthritis without rheumatoid factor, unspecified hand; pain in left shoulder; pain in left wrist; other intervertebral disc displacement, lumbar region; and radiculopathy, site unspecified. Comorbidities include X. Peer review dated X noted that the injury was consistent with a lumbar strain, cervical strain, and left shoulder strain. There is no indication that any diagnostic abnormality was specifically attributed to the alleged incident. All findings of MRI are X. Follow up note dated X indicates that the patient presents with complaints of low back pain radiating to the abdomen, left leg pain, left shoulder pain, and left wrist pain. The pain was rated X. On physical examination there is X. X index scored X for extreme, X component scale scored X for extreme, X scored X for moderate, X scored X for severe, and X scored X for moderate. Functional capacity evaluation revealed X. The claimant was recommended to have a X. Prior treatments included X. Treatments included in the program are listed as 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, “The Official Disability Guidelines recommend X. X may be recommended for X when all of the following are present, X. X. The claimant complained of low back pain radiating to the abdomen, left leg pain, left shoulder pain, and left wrist pain. The pain was rated X. Physical exam showed

X. X scored X for extreme, X scale scored X for extreme, X scored X for moderate, X scored X for severe, and X scored X for moderate. Functional capacity evaluation revealed X. The claimant was recommended to have a X. Treatments included in the program were X. However, the treatment course was not discussed. They only had X. They haven't had X to address psychological symptoms. Furthermore, the peer review noted that the compensable injuries were lumbar strain, cervical strain, and left shoulder strain which should have resolved by now. Thus, the request for X is noncertified." The denial was upheld on appeal noting that, "The physician sent a reconsideration letter stating that previous treatments included X. Surgical consultation was done and X was recommended. The treating provider indicated that the claimant had X. No reason was provided as to why they can't X. The claimant did not receive any X. The psychological evaluation revealed that they had X. Thus, the request for X is non-certified." There is insufficient information to support a change in determination, and the previous non-certifications are upheld. The submitted clinical records indicate that this patient presents with X. The submitted functional capacity evaluation indicates that results are considered X. Per peer review on X, the compensable injury was consistent with a cervical strain, lumbar strain and left shoulder strain. Strain was consistent with X. There is no additional diagnosis or condition considered compensable in this case. 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: *X*

☐ 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)