Core 400 LLC

An Independent Review Organization
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Description of the service or services in dispute:
XX

Description of the qualifications for each physician or other health care provider who reviewed the decision:
Board Certified Orthopedist

Upon Independent review, the reviewer finds that the previous adverse determination / adverse determinations should be:

- ☑ Overturned (Disagree)
- ☐ Upheld (Agree)
- ☐ Partially Overturned (Agree in part / Disagree in part)

Patient Clinical History (Summary)
XXXX who was diagnosed with other XX. XXXX sustained a work-related injury on XXXX, XXXX. The additional diagnoses were XX, XX, XX XX strain, and XX.

XXXX had an Impairment Evaluation by XXXX. The purpose of evaluation was to determine the extent of injury; based on that extent of injury, had XXXX reached maximum medical improvement, and if so, was any appropriate impairment assessed. XXXX opined that within a reasonable medical probability, the work-related accident caused the XX XX and XX XX XX at XX-XX and XX-XX. XXXX found that the compensable injury of XXXX was a substantial factor in bringing about the XX XX caused by the XX XX at XX-XX and XX-XX, and without the XXXX injury, those conditions would not have occurred. Specifically, the injury did not extend to include XX XX and XX XX XX at XX-XX and XX-XX. XXXX also stated that when the XX% for the XX XX was combined with the XX% for the XX XX, that yielded a total Whole Person Impairment Rating of XX%. In the injuries were limited XX XX strain, XX strain and XX XX not associated with XX-XX and XX-XX, XXXX found XX% Whole Person Impairment was appropriate.

On XXXX, XXXX was evaluated by XXXX for the follow-up of XX pain and XX XX pain. XXXX reported worsening of symptoms. The pain was XX type of pain rated as XX/10. XXXX had a recent work-related XXXX. The symptoms were aggravated by XX flexion, extension, rotation; prolonged sitting; lifting, and activity, and alleviated by rest. On examination, there was moderate limitation of XX XX range of motion secondary to pain. XXXX recommended that XXXX continue off work with no activities for a month and continue the medications.

XX / XX conduction XX report dated XXXX revealed normal XX of the XX XX extremity. No XX findings were noted for a XX XX or XX XX.

An MRI of the XX XX dated XXXX revealed moderate-to-marked XX XX XX XX XX at XX-XX and XX-XX. Moderate XX XX canal XX XX at XX-XX was noted. Mild XX XX XX XX XX was seen at XX-XX. There was XX XX XX at XX-XX, XX-XX, and XX-XX. There was moderate XX XX XX at the XX-XX level.

Treatment to date included medications (XXXX), XX therapy (XXXX), XX XX injection, and modified duty without significant benefit.

Per a peer review report dated XXXX, the request for XX-XX XX XX XX and XX was not medically necessary. The following was the rationale for noncertification of the request. In XXXX' note dated XXXX, XX days prior to XXXX note dated XXXX, there was no mention of XX pain. XXXX described XX and XX XX pain along with intermittent XX in the XX "XX" distribution. It was not clear whether the symptoms could be related to an XX XX. XXXX most recent note of XXXX assessed that XXXX was having XX pain and a XX XX. The history provided in that note and in XXXX prior notes was insufficient to support a diagnosis of XX. In the XXXX note, there were no details regarding the distribution / location, the frequency and the duration of the XX pain. In the XXXX note, there was no mention of the XX XX pain except in XXXX conclusion. In the XXXX note, there was mention of XX pain but no further details. In speaking with XXXX, XXXX stated that XXXX had XX and XX XX pain but no XX pain, which conflicted with some of XXXX notes. XXXX also stated that XXXX had XX and XX involving the entire XX XX, XX, and all the XX. There was only mild XX XX XX at XX-XX; hence, it was unlikely that XXXX had a XX XX. A XX XX would not cause XX and XX in the XX or XX XX. In the most recent examination by XXXX on XXXX, there were no objective findings of a XX, which was conflicting with the earlier XXXX note in which surgery was recommended for the XX XX XX pain and progressive XX of the XX XX. While the XXXX MRI showed moderate XX XX XX at XX-XX because of the vague and contradictory histories, it was not clear that XXXX was symptomatic from the XX. There was only mild XX XX at XX-XX. Given that the XX XX on the XX was mild at the level, there was unlikely to be nerve compression to cause a XX XX. While there was moderate / XX XX XX at XX-XX and XX-XX, there was insufficient history suggestive of a symptomatic XX and no documented examination findings of a XX to suggest that XXXX was symptomatic such that XX was indicated.

Per a utilization review determination letter dated XXXX, the request for XX-XX XX XX XX and XX was nonauthorized per peer review, as not medically necessary. It was determined that in XXXX' note dated XXXX, XX days prior to XXXX note dated XXXX, there was no mention of XX pain. XXXX described XX and XX shoulder pain along with intermittent XX in the XX "XX" XX. It was not clear whether the symptoms could be related to an XX neuropathy. XXXX most recent note of XXXX assessed that XXXX was having XX pain and a XX XX. The history provided in that note and in XXXX prior notes was insufficient to support a diagnosis of XX. In the XXXX note, there were no details regarding the distribution / location, the frequency and the duration of the XX pain. In the XXXX note, there was no mention of the XX XX pain except in

XXXX conclusion. In the XXXX note, there was mention of XX pain but no further details. In speaking with XXXX, XXXX stated that XXXX had XX and XX XX pain but no XX pain, which conflicted with some of XXXX notes. XXXX also stated that XXXX had XX and XX involving the entire XX XX, XX, and XX. There was only mild XX XX XX at XX-XX, hence it was unlikely that XXXX had a XX XX. A XX XX would not cause XX and XX in the XX or any XX. In the most recent examination by XXXX on XXXX, there were no objective findings of a XX, which was conflicting with the earlier XXXX note in which surgery was recommended for the XX XX XX pain and XX XX of the XX XX. While the XXXX MRI showed moderate XX XX XX at XX-XX, because of the vague and contradictory histories, it was not clear that XXXX was symptomatic from the XX. There was only mild XX XX at XX-XX. Given that the XX XX on the XX was mild at the level, there was unlikely to be XX XX to cause a XX XX. While there was moderate / XX XX XX at XX-XX and XX-XX, there was insufficient history suggestive of a symptomatic XX and no documented examination findings of a XX to suggest that XXXX was symptomatic such that surgery was indicated.

Per the peer review dated XXXX, the request for XX-XX XX XX XX and XX, purchase of XX XX, and purchase of XX XX XX for the XX XX following XX XX were noncertified. It was determined that XXXX reported pain in the XX that radiated down the XX XX and was rated as an XX/10 on the pain scale. XXXX had XX therapy and an XX XX injection with no significant benefit. Objective findings included limited XX range of motion secondary to pain. It was noted that there was no clear objective documentation of XX deficits in the XX through XX distributions indicative of XX. Therefore, the request for XX-XX XX XX XX and XX was not certified. Given that the request for XX-XX XX XX XX and XX had been recommended for noncertification, the request for XX XX for the XX XX to be used following XX fusion, as well as the request for purchase of XX XX XX for the XX XX were noncertified.

A reconsideration review decision letter dated XXXX, documented that the appeal for reconsideration of the request for XX-XX XX XX XX and XX had been reviewed and the original noncertification determination upheld. It was determined that XXXX reported pain in the XX radiating down the XX XX and rated as an XX/10 on the pain scale. XXXX had XX therapy and an XX XX injection with no significant benefit. Objective findings included limited XX range of motion secondary to pain. The XX XX MRI dated XXXX was reviewed. There was no clear objective documentation of the neurological deficits in the XX through XX distributions indicative of XX. Therefore, the request for XX-XX XX XX XX and XX was not certified.

Analysis and Explanation of the Decision include Clinical Basis, Findings and Conclusions used to support the decision.

The provided records would support the proposed XX XX from XX to XX as reasonable and medically necessary. In review of the claimant's imaging studies, there was XX present at XX-XX and XX-XX. The claimant presented with worsening XX XX functioning secondary to XX. The claimant has not improved with conservative treatment to date. Therefore, it would be appropriate to proceed with surgical XX and stabilization at XX-XX and XX-XX. As such, it is this reviewer's opinion that medical necessity is established and the prior denials are overturned.

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
☐ AHRQ-Agency for Healthcare Research and Quality Guidelines
☐ DWC-Division of Workers Compensation Policies and Guidelines
☐ European Guidelines for Management of Chronic Low XX Pain
☐ Interqual 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
☐ Texas TACADA Guidelines
☐ TMF Screening Criteria Manual
☐ Peer Reviewed Nationally Accepted Medical Literature (Provide a description)
☐ Other evidence based, scientifically valid, outcome focused guidelines (Provide a description)

Appeal Information

You have the right to appeal this IRO decision by requesting a Texas Department of Insurance, Division of Workers' Compensation (Division) Contested Case Hearing (CCH). A Division CCH can be requested by filing a written appeal with the Division's Chief Clerk no later than 20 days after the date the IRO decision is sent to the appealing party and must be filed in the form and manner required by the Division.

Request for or a Division CCH must be in writing and sent to:

Chief Clerk of Proceedings Texas Department of Insurance
Division of Workers' Compensation P. O. Box 17787
Austin, Texas, 78744

For questions regarding the appeals process, please contact the Chief Clerk of Proceedings at 512-804-4075 or 512- 804-4010. You may also contact the Division Field Office nearest you at 1-800-252-7031.