

Core 400 LLC
An Independent Review Organization
3616 Far West Blvd Ste B
Austin, TX 78731
Phone: (512) 772-2865
Fax: (512) 551-0630
Email: manager@core400.com

Information Provided to the IRO for Review

Emergency Department Records -X
Clinical Records – X
Discharge Summary Notes – X
Nurse Note – X
Respiratory Therapy Notes – X
Dietitian Notes – X
Utilization Review Letters –X,
Texas Workers' Compensation Work Status Reports –X,
Chiropractic Therapy Note –X,
Functional Capacity Evaluation – X
Letters – X
Notice of Adverse Determination - X
Report of Medical Evaluation – X
Functional Restoration Program Report – X
Adverse Determination Reconsideration Letter – X
Carrier Submission – X
Diagnostic Data Reports – X

Patient Clinical History (Summary)

X with a date of injury X. X had a X after X, when X was X. X was diagnosed with X I of unspecified X.

Per utilization review determination letter dated X by X, MD, the request for X performed under X was not-certified. it was determined that upon review of the clinical findings presented, sufficient evidence

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which were significant enough to warrant the requested X was continued to be limited. There was no mention that the requested X would be followed by intensive X. The request remained unsupported as clinical documentation continued to be limited to provide additional objective information to warrant the need for the request.

On X, X had a follow-up visit with X, MD. X reported having continued severe X, X changes, X, and X all consistent with X based on the hardened criteria. It was noted that X had received abundant X, rehabilitative care prior to even coming. X had exhausted all those measures and that was why X was requiring the next level of care. The extensive history and physical covered all the previous failures of treatment, surgical rehabilitative and medical, which led X to the referral for the intervention. The denial had led to increased healthcare cost, further disability, pain suffering, and was requiring ongoing further X support with potential further complications of centralized spread, which was complete contradiction to the Official Disability Guideline and the conventions of care for X. Furthermore, due to X pain, X, ASA III status as a board certified fellowship anesthesiologist, X required X not "X" that the doctor referred to. That was the convention of care to provide a still and stable surgical field. Given X X, X medication use, X medical history, X ASA III, and X would require the standard of care.

On X, X had a X Evaluation by X, DC. The results of functional capacity evaluation revealed that X was unable to X resume the usual and customary duties of X. X demonstrated the ability to return to modified duties with the following restrictions. X required job physical demand level (PDL) was X pounds (Heavy) and the ongoing physical demand level was X pounds (Medium / Heavy). X had completed initial X days /

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X hours in a multidisciplinary functional restoration program with significant success. It was recommended to continue for X more days or X hours to help X to continue cope with X ongoing X and given X further physical rehabilitative and vocational options. X continued with severe pain and with decreased function due to injury. X also continued consuming medications for pain control. During testing, X demonstrated a consistent performance and reproducible results comparing X physical assessment to X functional performance between the repeated activities of all the aspects of testing. X had some mild pain during the X, had some X, had some increased pain in the X, and increased pain in the X testing.

X, X was seen by X, MD for the completion of X sessions of X program. X described X pain as severe X. The pain was rated as X. On examination, there were signs of X. A DWC form-73 was completed stating that X would allowed to return to work as of X with the restrictions, which were expected to last through X. The restrictions were specifically applicable to the X, which included X objects more than X pounds per day.

An MRI of the X dated X showed X. Marked X, including involving the X due to underlying X. X had a history of recurrent X, X also would be of concern. X, could not be excluded. If there was clinical concern for X, a X or a X scan could be performed for further evaluation. X.

Treatment to date included medications (X), surgical intervention (X X on X and X, Reconstruction of X with X, Adjacent X, and X on X with the application of X.), Individual X, X.

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Per utilization review determination letter dated X by X, MD, the request for X was denied. It was determined that there was no mention that the requested X would be followed by X. Clarification was needed regarding the request and how it might affect X clinical outcomes.

Per utilization review determination letter dated X by Dr. X the request was non-certified. Rationale: “Based on the clinical information submitted for this review and using the evidence-based, peer-reviewed guidelines referenced above, this request is noncertified. Upon review of the clinical findings presented, sufficient evidence which are significant enough to warrant the requested X is still limited. There was still no mention that the X will be followed by X. The request remained unsupported as clinical documentation still was limited to provide additional objective information to warrant the need for the request.

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

Both reviewers stated that the absence of a plan of X(X) after the X (X) precluded approval of the request for the X. The provider has documented the patient’s presenting symptoms which meet the XX criteria for X. The provider has provided the rationale for the X and clearly stated (clinical notes dated X) that a plan of X in conjunction with the X is planned. Given the documentation available, the requested service(s) is considered X.

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

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- 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
- 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

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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.