Core 400 LLC
An Independent Review Organization
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Review Outcome

Description of the service or services in dispute:
X
Description of the qualifications for each physician or other health care provider who reviewed the decision:
Board Certified Orthopedic Surgery

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)

Information Provided to the IRO for Review

- Clinical Records – X
- Occupational Therapy Notes – X
- Utilization Reviews – X
- Peer Reviews – X

Patient Clinical History (Summary)

X is a X -year-old X who was diagnosed with X, X, subsequent encounter (X), X, closed displaced X with routine healing, subsequent encounter (X), and complex regional pain syndrome type 1 of X extremity (X).

On X, X was evaluated by X, MD for X pain. X stated that the symptoms were X and X and began on X. X indicated that the injury occurred at X The symptoms were X at the time. The pain was described as X and X. On examination, the X degrees, long X degrees, and X degrees. The XX, long X degrees. The X degrees, X degrees, and X degrees. The X digital X. X XX were noted.

X was seen by X, MD on X for X pain. The symptoms were X. X experienced pain on top of the X. The symptoms were aggravated with daily activities and relieved with rest and pain medications. In addition to the X, X also experienced decreased X. X had stiffness to the X on the X and had been attending formal therapy. X hypersensitivity was tolerable and X XX was not working. On examination, the X was X degrees. There was a X noted. X was limited and X was noted.

Treatment to date consisted of X with some improvement, X and internal fixation of the X, X on X, X
Per a utilization review determination letter by X, MD dated X, the request for X was non-certified. It was determined that the records submitted for review would not support the requested procedures as reasonable or necessary. Routine x of pain such as infection and nonunion. That was not evident in the records provided for review. The records did not document any conservative treatment to include physical therapy. It was unclear if X had reached a X or failed to progress with formal therapy. No updated imaging of the X were submitted for review. Given those issues which did not meet guideline recommendations, Dr. X could not recommend certification for the requests.

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Notice of Independent Review Decision

Case Number Date of Notice: 06/25/19

A letter dated X by X MD indicated that the reconsideration request for was denied / non-certified. Rationale: “This request is not supported at this time. There has been significant improvement with this claimant's pain sense. There has been use of a X. This had allowed X to increase X efforts and progress with occupational therapy. The occupational therapy note on X does not indicate that therapy has been exhausted, or that no more improvement is expected to consider surgery at that time. Without any documentation that occupational therapy has exhausted its efforts, this request for Reconsideration: X, unspecified if inpatient or outpatient [X], for the submitted diagnosis X not medically necessary.”

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

The ODG supports X for the treatment of X when injured workers are committed to X and there is intact innervation and good strength. The ODG supports X when other causes have been ruled out. The documentation provided indicates that the injured worker has significant X with evidence of X. Previous treatment has included X. The treating provider has recommended a x and a x. Based on the documentation provided, the ODG would support the requested x as there indicated for the treatment of x. It is unlikely that the injured worker will gain range of motion without x care. The ODG would not support the requested x as there is no indication that there is painful hardware and the other causes of pain have been ruled out. As such, partial certification is recommended for the requested x and noncertification is recommended for x. Based on the records provided, the request is partially medically necessary.

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 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

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.