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

Notice of Disputed Issues(s) and Refusal to Pay Benefits – XX
Physical Performance Evaluations – XX
Peer Review Reports – XX
Reassessment for XXXX Restoration Program Continuation – XX
Request for 80 Additional Hours of a XXXX Restoration Program – XX
Utilization Reviews – XX
Continuation XXXX Restoration Program Preauthorization Request – XX

Patient Clinical History (Summary)

XXXX. XXXX XXXX is a XXXX-year-old XXXX who was injured on XXXX. XXXX XX XX package that appeared to be too small to be in the XX As XXXX released the XX from the XX, the XXXX was XX back, and XXXX felt a sharp, instant pain to XXXX XX XXXX was diagnosed with XX , XX and XX at the XX and upper XXXX level, right XXXX, initial; and XX, right XXXX.

On XX, a physical performance evaluation was conducted at XX. XXXX. XXXX presented with complaints of constant XX XXXX and XXXX pain with weakness. On examination, XX XXXX flexion was 108 degrees, extension 20, horizontal adduction 25 degrees, abduction 75 degrees, internal rotation 46 degrees and external rotation 26 degrees. There was unilateral weakness on XX Static muscle testing revealed weakness due to deconditioning of the area of injury. XXXX. XXXX could not completely perform in the XX XX -pound medium lifting category on an occasional basis. Therefore, XXXX must be listed in the light-to-medium category and should be restricted to no more than XX pounds of dynamic lifting on an occasional basis and XX pounds on a frequent basis. Per the assessment, XXXX. XXXX could not safely perform XXXX job demands based on comparative analysis between XXXX required job demands and XXXX current evaluation outcomes. XXXX was at a PDL medium XX pounds and remained at PDL medium 20 pounds. XXXX had lost some of the strength XXXX had gained during XXXX first XX hours of XX due to deconditioning related to XXXX hospitalization for an invasive XX. The current evaluation indicated XXXX. XXXX could not safely perform XXXX occupational full-time, full-duty job demand PDL of heavy XX pounds. XXXX would benefit from continuation of the interdisciplinary XXXX program to further strengthen and improve XXXX capabilities as well as improving pain-coping mechanisms.

On XX, a request for additional XX hours of a XXXX XXXX Program was made. Per the report, XXXX. XXXX continued to report marked pain and unresolved XXXXX problems that were associated with reliance on significant others to complete ADLs. XXXX treating doctor had recommended participation in an Interdisciplinary XXXX Restoration Program. XXXX current versus baseline scores had improved on FABQ, CSQ-R, Oswestry Disability Index, Beck XX Inventory XX , Beck XX Inventory (XX-II), VAS of Patient Symptom Ratings Scale. Clearly, the program had exerted a positive impact on XXXX symptoms; however, XXXX had not met the targeted reduction of 75% in every active symptom. XXXX required an additional XX hours / units of the interdisciplinary XXXX rehabilitation program in order to extinguish active symptoms over a long-term basis, maximize XXXX XXXX tolerances, and propel XXXX toward a safe return to work. XXXX previous physical demand level was medium, and the current was medium; however, the required PDL was in the heavy category. Dr. XX has evaluated XXXX. XXXX and noted that XXXX is an appropriate candidate for progression to a XXXX Restoration Program. Based upon the available records, prescription from XXXX referring doctor, information gathered

across assessment periods, and limited response to low-level treatment, XXXX. XXXX was a suitable candidate for a tertiary level of care. Conservative care had not been sufficiently intensive to help XXXX increase XXXX physical functioning capacity or reduce psychological distress. XXXX required a daily, intensive, team-oriented program that would stabilize active symptoms on a long-term basis and assist XXXX with return to work options. XXXX met the criteria required for referral to a multidisciplinary XXXXRestoration Program.

Treatment to date included medications (XXX XX XXX), XX sessions of XX (XX, XX / XX and XX unit) and XX hours of a XXXX Restoration Program; however, the goals were not met.

A peer review dated XX and a utilization review dated XX was completed by Dr. XX. XXXX opined that the request for additional chronic pain / XX Restoration Program for XX hours for the XX XXXX was not medically necessary. Rationale: "The history and the documentation do not objectively support the request for an additional XX hours of this XX. The ODG support up to XX hours, which have been completed, and the claimant remains significantly symptomatic with XXXX deficits. Outlier status has not been described. There is no clinical information that warrants the continuation of this program for an extended period of time. The medical necessity of this therapy has not clearly been demonstrated. A clarification of XXXX progress and anticipated goals was not obtained. Therefore, the request for additional chronic pain / XXXX Restoration Program for XX hours for the XX XXXX is not medically necessary."

On XX, a request for reconsideration was placed by XX. This was for additional XX hours of chronic pain / XXXX Restoration Program from XX. The diagnoses were XX XXXX XX /XX, XX XX, XX XX, and possible small XX. It was stated that at the time, XXXX. XXXX continued to report marked pain and unresolved XXXX problems that were associated with reliance on significant others to complete ADLs. XXXX treating doctor had recommended participation in an Interdisciplinary XXXX Restoration Program. Clearly, the program had exerted a positive impact on XXXX symptoms; however, XXXX had not met the targeted reduction of 75% in every active symptom. XXXX required an additional XX hours / units of the Interdisciplinary XXXX Rehabilitation Program in order to extinguish active symptoms over a long-term basis, maximize XXXX XXXX tolerances, and propel XXXX toward a safe return to work." In summary, the prior treatment modalities had failed to stabilize XXXX. XXXX' XX XX, increase XXXX engagement in activities of daily living, or enhance XXXX physical functioning such that XXXX could safely return to work. XXXX had developed a chronic pain syndrome; the treatment of choice was participation in an interdisciplinary XXXX Restoration Program. Based on progress made within 80 hours of the program, XXXX. XXXX's treating doctor had prescribed participation in an interdisciplinary XXXX Restoration Program as medically necessary. This intensive level of care was needed to reduce XXXX. XXXX' pain experience, develop self-regulation skills, and facilitate a timely return to the workforce. Thus, authorization for XX hours / units days in a XXXX Restoration Program appeared reasonable and medically necessary for a lasting management of XXXX pain symptoms and related psychosocial problems, as it was the recommended treatment of choice for patients with chronic pain syndrome."

XX DO performed a peer review on XX. Rationale: "Per the records, the patient has already completed a total of XX hours of a XXXX Restoration Program (FRP) for the XXXX with improvement. The patient was given Biofreeze. The patient's medications included XX and XX. The ODG support up to XX hours which have been completed, and the claimant remains significantly symptomatic with XXXX deficits. There is no clear evidence provided or proven by the provider based on documentation of extenuating circumstances to meet eligibility for an exception in this case. Also, the provider did not document the failure of other alternatives such as psychiatry follow-up, home exercise program and adjusting XXXX medication to help with the symptoms. Based on the current guidelines and provided documentation, the patient would not

meet necessity for additional chronic pain / XXXX Restoration Program for XX hours for the XXXX. Therefore, the requested appeal for additional chronic pain / XXXX Restoration Program for XX hours for the XX XXXX is not medically necessary."

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 Continuation of XXXX Restoration Program XX – Unlisted rehabilitation procedure (80 hours) is not recommended as medically necessary, and the previous denials are upheld. There is insufficient information to support a change in determination, and the previous non-certification is upheld. The patient has previously completed XX hours of XXXX restoration program. Current evidence based guidelines support up to XX hours of XXXX restoration program, and there is no clear rationale provided to support exceeding this recommendation. When treatment duration and/or number of visits exceeds the guidelines, exceptional factors should be noted. There are no exceptional factors of delayed recovery documented. The patient's physical demand level has remained medium. Beck scales remained the same. 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
- ☐ 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

Case Number: ***XX*** Date of Notice: 05/15/19

☐ 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.