

Core 400 LLC
An Independent Review Organization
3616 Far West Blvd Ste 117-501 C4
Austin, TX 78731
Phone: (512) 772-2865
Fax: (512) 551-0630
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 X

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

X

Patient Clinical History (Summary)

X who was injured on X. X was X. X was diagnosed with X.

X was seen by X, DO on X and X. On X, X continued to X. The problem was that X. X.” On examination, there was X. X was X. On X, X presented for a follow-up. X was X. The X became X. There were some signs of X. As a result of this X, X was X. The pain was back to X. Dr. X opined that X. X continued to X.

The treatment to date included X.

Per a utilization review decision letter dated X, the request for X was denied by X, MD. Rationale: “Per the reviewed literature, the complications of X have been reported to be at X, X. The recent

literature stated the X. X were required for these cases. In this case, the patient was X. The problem was X. On examination, it was X. The provider recommended X. Per clinical indication, medical necessity is supported.”

Per an adverse determination letter dated X, the prior denial was upheld by X, MD. Rationale: “Per the reviewed literature, the complications of X. A X was made; however, the recent literature still stated the following X. X were still required for these cases. It was noted that the patient was X. Clarification is needed regarding the request and how it would affect the patient’s clinical outcomes. The prior determination is still upheld.”

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

This patient has a X. The X. This becomes X. In this patient, it appears that the “X” was initially X. It appears to X. The provider wants to X. Two prior utilization reviews denied this request citing that X. However, there was X. While the ODG does not have specific guidelines related to this patient’s presentation, “X” appears to have X. An X is needed to X. Given the documentation available, the requested service(s) is considered 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
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- 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
- 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.