

**Core 400 LLC**  
**An Independent Review Organization**  
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***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. Since then X had X and X. X was diagnosed with X.

On X, DO noted that X had X. X was X, and X was evaluated by Dr. X and the provider. X was consistent X or the remainder of X. X wanted to get X. X was X. X was X. X including X. X showed X. On X presented with continued X. X complained of X. X did X. X stated X. On examination, X had X.

An MRI of the X.

Treatment to date included medications X.

Per Adverse Determination by X, MD on X the request for X was noncertified. Rationale: "Per ODG X "Recommended, but no more than X. X may be performed with the X. See X. See also the X and X. Criteria for the use of X. 1. X. The pain response should X 2. X to patients with X. The

x presented with X. There is a X. The X. X are not recommended in this clinical scenario. In addition, there is no mention of these X in the latest chart note. Overall, the request for a X is not medically necessary.”

Per Reconsideration of an Adverse Determination by X, MD on X, the request for X was noncertified. Rationale: “The injured worker is a X. The injured worker was diagnosed with X. Per the ODG guidelines, diagnostic X were recommended for evaluation or X. of the same. X are not generally recommended for the treatment of X. In this case, the intent of the requested X. The most recent clinical encounter note states, “We are recommended a X. First, however, the referring doctor wants us to resolve the ongoing X.” There is no mention of the consideration of X. Additionally, was the intent diagnostic, clarification is needed to determine if the X. Compliance with the X and medical necessity are not established by the information provided. Thus, the request is non-certified.”

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

This patient X for which X. The provider initiated care in X. Since the patient’s symptoms were X. An MRI in X, failed to X. X reviews denied the request for a X, citing the lack of documentation supporting the request. If the X may be indicated, depending on the patient profile. If X is approved, X be used since they may confound the X. Typically, X may be used. Given the documentation available, a portion of 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)