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
Email: @core400.com

Notice of Independent Review Decision

IRO REVIEWER REPORT

Date: X

IRO CASE #: X

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: X

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: X

REVIEW OUTCOME:

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

☐ Overturned Disagree

☐ Partially Overtuned Agree in part/Disagree in part

☒ Upheld Agree

X.

INFORMATION PROVIDED TO THE IRO FOR REVIEW: • X

PATIENT CLINICAL HISTORY [SUMMARY]: X who was injured on X. The mechanism of injury was not available in the provided medical records. Please note, no office visits, imaging studies, or treatment to date were available in the provided medical records. Per a utilization review adverse determination letter and peer review report dated X by X, MD the request for X was denied. Rationale: "The principal reason(s] for denying these services or treatment: treatment has been limited to X. The clinical basis for denying these services or treatment: ODG notes X is usually contraindicated with any imaging presence of X. According to the evidence-based guidelines, for X in younger patients. Not recommended for X. The patient has X with most pronounced symptoms at the medial compartment. Treatment appears to be limited to X. Examination noted X. There was a report of pain, but there was no report of mechanical symptoms, which are required per guidelines in the setting of X. Therefore, my recommendation is to NON-CERTIFY the request for X." Per a reconsideration review adverse determination letter dated and peer review report dated X by X, MD, the appeal request for X, was denied. Rationale: "The principal reason(s) for denying these services or treatment: the patient has advanced X. The clinical basis for denying these services or treatment: ODG states X is usually contraindicated with any imaging presence of X. Since the time of the last review. There are no additional records for review. The prior review denied the request based on findings of X. The prior rationale remains relevant. Per guidelines X is not recommended for X. The reviewed imaging notes the patient has X. Treatment has been limited to X. The recent report did not note any mechanical findings which are required per guidelines in the setting of X. Therefore, my recommendation is to NON-CERTIFY the appeal requests for X." Based on the medical documentation, the requested procedure is not medically necessary. The patient has X. Examination noted X. There was a report of pain, but there was no report of mechanical symptoms, which are required per guidelines in the setting of X. X is not medically necessary and non certified

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:

Based on the medical documentation, the requested procedure is not medically necessary. The patient has X. Treatment appears to be limited to X. Examination noted X. There was a report of pain, but there was no report of mechanical symptoms, which are required per guidelines in the setting of X. X is not medically necessary and non certified
Upheld

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

☐ **ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE**

☒ **ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**

☐ **AHRQ- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES**

☐ **DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR 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**

☐ **PRESLEY REED, THE MEDICAL DISABILITY ADVISOR**

☐ **TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & 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)**