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
Amendment

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

Provide a description of the review outcome that clearly states whether medical necessity exists for **each** of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW: X

PATIENT CLINICAL HISTORY [SUMMARY]: X is a X who was injured on X. X was X on X, X. The diagnosis was X and X, status X. On X, X was evaluated by X, MD for X pain. X had a X examination X on X with X, X with Dr. X. X continue having X, X

since the X. X had not X and X. X worked as X and said X. On examination of X, there was X, with X. X was X. X were X. X was X. X was X. On X, X was seen by X for follow-up of X. X stated that X. X had started X. X had X. This was due to medication for X as well as X. X stated that X. X stated that X continued having constant, X in X since X. X had not provided X and X. X worked as X and said X. X rated X pain X. X examination revealed X. The range of motion was X. X wanted to X. An X of the X dated X showed X. Treatment to date X. Per a utilization review adverse determination letter dated X by X, MD, the request for X was denied. Rationale: "ODG notes that X. In this case, there is no documentation of the claimant's X. There is no evidence that the claimant X. The claimant has X. In addition, there is no evidence of X. Thus, the medical necessity of this request is not established. Recommend non-certification. The requested X is not medically necessary. The most recent medical record is from X whereby the patient has X. The patient has had X. The X submitted from X demonstrate X. However, there is no documentation of X. The X report from the X has not been submitted for review to determine the X. Thus, the requested X is not medically necessary. 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:

The requested X is not medically necessary. The most recent medical record is from X whereby the patient has X. The patient has had a X. The X submitted from X demonstrate X. However, there is no documentation of X. The X report from the X has not been submitted for review to determine the X. Thus, the requested X is not medically necessary. 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**

☐ **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)**