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

INFORMATION PROVIDED TO THE IRO FOR REVIEW: • X

PATIENT CLINICAL HISTORY [SUMMARY]: X who sustained an injury on X. The biomechanics of the injury is not included in the provided records. The diagnoses included lumbar radiculopathy, cervical radiculopathy, chronic pain syndrome, lumbar post-laminectomy syndrome, and neck pain. X was seen by X, MD on X for lumbar spine pain. X reported the pain radiated to right lower extremity (posterior lateral thigh). X endorsed low back pain (right more than left), right buttock pain, and right hip pain. The pain had been present for more than X years. The pain was described as X. The pain was worsening and interfering with sleep and work. It was aggravated by sitting, standing, walking, and using stairs. It was associated with catching and locking. X was unable to find a position for comfort. On examination, X appeared too thin and in severe distress. X was limited. Mental status examination was notable for X. Cervical spine active X was limited due to X. X were noted. Motor strength with knee extension right quadriceps was X, ankle dorsiflexion, right tibialis anterior X, and great toe extension right extensor hallucis longus was X. There was tenderness noted X. X was decreased in right foot. X revealed X. X was noted. It was noted that in the past X had procedures X a year because X needed them and X got good relief that enabled X to function. X had been the only treatment that gave X relief. Following the previous procedure X pain decreased to X, able to X. X needed imaging to be approved so, X could have the procedure and get some relief and a life. An MRI of the lumbar spine on X showed X. However, CT would better evaluate for X. Treatment to date included X. Per the peer review by X, MD on X, the request X was non-certified. Rationale: “The claimant has lumbar radiculopathy. ODG has specific X. The claimant has none of these conditions. The indication for X is not

documented. Therefore, the request for a X is not medically necessary." The request for X was non-certified. Rationale: "The claimant has lumbar radiculopathy. ODG has specific X. The claimant has none of these conditions. The indication for X is not documented. Therefore, the request for a X is not medically necessary."Per the peer review by X, MD on X, the request for X was non-certified. Rationale: "In this case, claimant has X. X has been treated with X. MRI showed X. Mild to moderate facet arthrosis with greatest foraminal narrowing severe at the right X. There is also moderate bilateral X foraminal stenosis. Post-surgical changes throughout the lumbar spine with apparent bilateral facet joint bony fusion at X. However. CT would better evaluate X. However, there is no evidence of X. Therefore, the request for X is not medically necessary." The request for X was non-certified. Rationale: "In this case, claimant has X. X has been treated with X. However, there is no evidence of X. Therefore, the request for X is not medically necessary."The requested X are not medically necessary. The medical guidelines do not support the use of this test for the associated diagnosis. The medical records do not demonstrate the presence of a X. No new information has been provided which would overturn the previous denials. 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 are not medically necessary. The medical guidelines do not support the use of this test for the associated diagnosis. The medical records do not demonstrate the presence of a X. This type of scan is not necessary to evaluate X as a regular CT scan is appropriate. No new information has been provided which would overturn the previous denials. 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)**