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 was injured at work on X while X. The diagnosis was chronic back pain syndrome with lumbar disc disruption and spondylosis X following work injury with persistent left lumbar radiculopathy amenable to interventional pain care over X; lumbar spondylosis X with neural foraminal stenosis associated with chronic back pain syndrome with lumbar disc disruption and spondylosis X following work injury with persistent left lumbar radiculopathy amenable to interventional pain care over a year ago; and secondary myofascial pain syndrome with generalized deconditioning. Per a follow-up visit note dated X by X, DO, X was continually more than X improved following X. X received this care with good treatment and was thankful. X did receive X. In fact, X became squeamish, thinking what it would be like to stick a X. Dr. X noted that X. Dr. X noted they were not asking for anything additional. They were asking for the X, which ameliorated or relieved the natural compensable disease state, which was consistent with the Texas Labor Code. Furthermore, the medical board supported intervention with appropriate sedation and anesthesia in light of the opioid epidemic. They limited the use of X. X was on X. X was working on X. Dr. X noted X would resubmit for X as previously delivered safely and effectively. The patients who did move during the procedure had a higher likelihood of developing a X. This minimal sedative, which was provided in a safe and satisfactory manner, was being asked for. At the time, X showed X. X was X. X was X. X was X. X was X. X was satisfactory. X was consistent with these agents and Dr. X would arrange for this as soon as possible. Further delays would lead to further deconditioning and they would schedule for this as soon as possible. Treatment to date included X. Per a utilization review adverse determination letter dated X by X, MD, the prospective request for X was non-certified. Rationale: “In this case, X is not generally recommended. In addition, it is unclear why X. Therefore, the request for X is noncertified.” Per a reconsideration review adverse determination letter dated X, the appeal request for X was noncertified by X, MD Rationale: “In this case, the information provided does not support the request as there is no record of extraordinary circumstances that would X. X is not recommended and there is no record of factors that would indicate such X. If only

X is planned, it is unclear why X. Although a X may be, reasonable, given prior relief, X is not shown to be medically necessary. Since the request cannot be modified, the request is not medically necessary. Therefore, the request for X is non-certified." Based on review of the provided records the claimant reported more than X improved following X. The provider notes that during the prior X the claimant presented with X. However, the provider has submitted a request for X. There is no record of extraordinary circumstances that would necessitate X. As such, X is medically necessary and certified and 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 review of the provided records the claimant reported more than X improved following X. The provider notes that during the X. However, the provider has submitted a request for X. There is no record of extraordinary circumstances that would X. As such, X is medically necessary and certified and X is not medically necessary and non certified
Partially Overturned

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)**