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 X

IRO REVIEWER REPORT

Date:X, Amendment 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.

Per a Report of Medical Evaluation dated X, X, MD evaluated X for a Designated Doctor Examination (DDE) to determine maximum medical improvement (MMI) and if so, assign an impairment rating as well as to determine extent of X compensable injury. Review of records was done. An MRI of lumbar spine dated X revealed X. At X, there was X. At X, there was X. At X. There was X. At X. There was X. At X. There was X. There was X. At X. Per a follow-up visit dated X, X, MD evaluated X. X reported going to X which was not helpful. X had both back and leg pain. X said that when X walked, X could walk about one block and then X legs go away. X was prevented from working. Lumbar spine examination revealed X. There was X. There X. X continued with loss of range of motion in flexion to X degrees, extension to X degrees, right and left flexion to X degrees and no muscle atrophy noted in either lower extremity. Heel toe walk was abnormal with X reporting that X underwent X. Abdomen examination revealed X. Bowel sounds were normal and no X. X reported continued difficulty with activities of daily living which involved bending over and lifting objects from low levels. Dr. X opined that X had not reached X MMI because X continued to have pending additional treatment expected to improve X condition and would not be able to be at MMI until X completed X treatment. Impairment rating could not be assigned as X has not reached MMI. The mechanism of injury on X which X was X. The specifically, the work accident on X was the substantial factor in causing the X. Without the accident, X would not have required X.

Treatment to date included X.

Per a utilization review adverse determination letter dated X by X, DO, the request for X was denied. Rationale: “With regards to the X request, as stated in the guidelines. X is recommended, and that given X should be X. ODG guidelines allow for X (from up to X visits per week to X or less), plus active self-directed home PT. Guidelines indicate that for X: X is appropriate. Guidelines recommend that X should be X. The most commonly used active treatment modality is X), but other active therapies may be recommended as well, including X. X, and X. ODG states that it is generally not recommended as a X. In this case, the clinical summary states that the date of injury (DOI) was in X and it is unclear how much X may have taken place in the past. There is no documentation of the Objective functional improvement through prior therapy. Also, it is unclear why X is being requested which exceeds guideline recommendations and unclear why patient cannot be directed to a X. Also, no recent exacerbations to clarify why X is necessary. Therefore, the request for X is hereby recommended not certified.”

Per a reconsideration / utilization review adverse determination letter dated X, by X, MD, an appeal request for X was denied. Rationale: “This is an appeal request for X. The ODG recommends up to X. The ODG does not support X. The documentation provided indicates the claimant has chronic low back pain with a diagnosis of lumbar stenosis. They have objective functional impairments on physical examination. The provider has recommended X, but it is still unclear how much X has taken place, what objective functional improvement has been seen by the completed therapy, and why the claimant cannot proceed with a home exercise program. As such, the request for X is non-certified.”

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL

BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:

On review of the provided records the claimant has chronic low back pain and underwent X . the records indicate X has been performed that was not helpful. There is no documentation of inability to perform home exercises. The number of treatments to date and objective response were not provided and the records do not reasonably indicate further improve with additional physical therapy treatment. As such, the request for X is not medically necessary.

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)**