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)

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. The biomechanics of the injury is not available in the records. The diagnosis was low back pain, lumbosacral radiculitis, cervical post laminectomy syndrome, chronic pain syndrome, presence of intrathecal pump, and therapeutic opioid induced constipation. On X, X, MD evaluated X via video visit for pain in lower back. The pain level was a X. Pain level with medication was X and pain level without medication was X. The quality of pain was sharp. Life improvements with medications included some light activates. Since the last office visit the pain was improved. Since the initial office visit, the pain was improved. The pain was made worse by activity, standing and walking. The pain was made better by rest and medications. Sleep quality was fair. The timing of pain was around-the-clock. X felt that X ongoing pain control was adequate. X was having constipation with medications. On examination, X had a smart device for assistance. An MRI of lumbar spine dated X revealed X. Above the level of X. On X, X, FNP-C evaluated X via telemedicine for ongoing pain of lower back. The pain level was X at the time. The pain level with medications was X and without medications was X. The pain quality was sharp and throbbing. Life improvements with medications included the ability to sit more and walking. Since the last office visit, the pain was improved. Since the initial office visit, the pain was improved. The pain was made worse by activity and walking and made better by medications. Sleep quality was fair. The timing of pain was around-the-clock. X felt that X ongoing pain control was adequate. X felt that X was having constipation with medications. On examination, X had a smart device for assistance. A urine drug screen dated X X. Treatment to date included X. Per a peer review and utilization review adverse

determination letter dated X by X, MD, the request for X was denied. Rationale: In this case, there is no record of improvements in pain or function attributable to X. Despite the use of the X, the injured worker has been unable to X. The request is not shown to be medically necessary. Therefore, the request for X is non-certified “Per an appeal letter dated X, a reconsideration request for X, was made on X. Per a peer review and reconsideration / utilization review adverse determination letter dated X by X, MD, the request for X was denied. Rationale: “The injured worker was diagnosed with low back pain. In this case, the injured worker underwent a X on X. The injured worker reports lower back pain rated at X, which decreases to X with medications but increases to X without. The last X was administered on X, with an X. The injured worker reports experiencing constipation as a side effect of the medications but overall reports adequate pain control and improvements in daily activities such as sitting and walking with the assistance of medications. However, upon examination, no significant objective findings were noted. The provider has requested an appeal for X. There is a previous denial dated X. Given the absence of significant objective findings and the injured worker's reported adequate pain control and life improvements, the request for X does not meet the criteria outlined in the medical guidelines and is, therefore, not considered medically necessary. As such, the appeal request for X is non-certified “Based on the submitted medical records, there are no records to demonstrate objective and functional improvements with the use of the X. No new information was provided to 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:

Based on the submitted medical records, there are no records to demonstrate objective and functional improvements with the use of the X. No new information was provided to 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)**