

Core 400 LLC  
*Notice of Independent Review Decision*  
Core 400 LLC  
An Independent Review Organization  
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*Notice of Independent Review Decision*  
*Amendment X*  
*Amendment X*

**IRO REVIEWER REPORT**

**Date:** X: Amendment 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)

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- 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 mechanism of injury was not available in the medical records provided. The diagnoses were (X) other cervical disc displacement, unspecified cervical region (X), other spontaneous disruption of anterior cruciate ligament of left knee (X), unspecified dislocation of left shoulder joint, subsequent encounter and (X) sprain of ligaments of thoracic spine, initial encounter. There was no office note or current imaging provided for review in the medical records. Treatment to date included X. Per a utilization review adverse determination letter dated X by X, DC, the X was denied. Rationale: “Based on the clinical information submitted for this review and using the evidence-based, peer reviewed guidelines referenced below, this request is non-certified. The claimant has been seen for X. The claimant states in the initial note of X, X did do several visits with a X. The notes reviewed show the patient has not made any significant functional gain since starting treatment with Dr. X. A MRI has been performed. It shows X. There is also X. Their goal is to have the patient seen by X. Since functional gain has not been noted in the records, the request for X has not met the medical necessity based on the guidelines. “Per a reconsideration review adverse determination letter dated X by X, DC, the appeal request for X was denied. Rationale:

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“Based on the clinical information submitted for this review and using the evidence-based, peer reviewed guidelines referenced below, this request is non-certified. Based on the clinical information provided, the APPEAL request for X is non-certified. The initial request was non-certified noting that, "The claimant has been seen for X. The claimant states in the initial note of X, X did do several visits with a X. The notes reviewed show the patient has not made any significant fictional gain since starting treatment with Dr. X. A MRI has been performed. It shows X. There is also X. Their goal is to have the patient seen by X. Since fictional gain has not been noted in the records, the request for X has not met the medical necessity based on the guidelines." There is insufficient information to support a change in determination, and the previous non-certification is upheld. The submitted clinical records indicate that the patient has X. Guidelines would not support ongoing treatment without documentation of progress. Also, the patient has X. Therefore, medical necessity is not established in accordance with current evidence-based guidelines. “Thoroughly reviewed provided records. Patient with X. Based On cited guidelines, X requested is not indicated. 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:**

Thoroughly reviewed provided records. Patient with X. Based On cited guidelines, further X requested is not indicated. X is not medically necessary and non-certified.

Upheld

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**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)**