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***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 Overturned (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 who was injured on X. X sustained an injury in a X. X was a X. The diagnosis was cervical sprain / strain and lumbar sprain / strain. On X, X, MD evaluated X for a follow-up visit. X felt about the same. The pain was described as sharp, burning, and throbbing, rated X pain. X was unable to work. The pain was constant pain, made worse by all X activities, better by just sitting. X had no new symptoms. X was following the treatment plan, but it was not helping. X was denied X. X also complained of low back pain radiating through right lower extremity with X noted on the MRI. X had multiple sessions of X. Home exercises had not helped. X had an MRI of X. Cervical MRI had been addressed by spine surgeon. A X had been denied. On examination, the low back and neck pain radiated into the right lower extremity. A request for X was requested followed by X. X had lack of improvement with X. X had reached a point where the decision was to proceed with an X which was based upon the complex nature of the injury, how it was impacting X bodily function as well as the fact that they had exhausted all X. Per records, an MRI of lumbar spine dated X was reviewed which showed X. At the X. There was X. There was associated X. Spur disc complex abutted the X. There was X. At the X. X was noted more toward the right without X. There was X. X noted. There was X. At the X. X was noted more prominent in the X. X was noted. X noted. There was X. Treatment to date included X. Per a utilization review adverse determination letter dated X, the request for X was denied by X, MD. Rationale: "Based on the medical records and guideline recommendation, the request for a X is not warranted. The claimant has a history of neck and low back pain with complaints of X. They reported low back pain radiating through the right lower extremity and the exam of the lumbar spine stated there was low back pain that radiated into the right lower extremity. It was also noted that an MRI of the lumbar spine showed a X. The MRI report was not submitted for review. An X is recommended for lumbar radicular pain when there is radiation of pain and numbness along the distribution of a specific spinal nerve root and diagnostic imaging correlates with symptoms. Use of X is not recommended. Although the claimant has complaints of pain and radiculopathy, they do not meet the criteria for surgery as the exam did not document a lumbar

radiculopathy along any specific lumbar nerve root. The claimant did not have numbness, loss of sensation, loss of reflex, or pain specific to any nerve root. Therefore, the request for X is non-certified. "Per a reconsideration review adverse determination letter dated X, the request for X was denied by X, MD. Rationale: "The request for X was non-certified by Dr. X in review X. The physician reviewer noted that the neurological exam did not reveal evidence of lumbar radiculopathy along any specific lumbar nerve root. Subsequently, an appeal request without any specific rebuttal to the rationale for non-certification was submitted for review. The original determination was appropriate. X require evidence of lumbar radiculopathy and imaging correlation for treatment. Remarkably, the most recent neurological evaluations have not revealed any X. Hence, the request for X is noncertified. "The requested X is not medically necessary. The submitted imaging report and clinical examination does not demonstrate X. Furthermore, the use of X is not recommended. 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 is not medically necessary. The submitted imaging report and clinical examination does not demonstrate X. Furthermore, the use of X is not recommended. 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)**