

Core 400 LLC

Notice of Independent Review Decision

Case Number: X

Date of Notice: X;Amendment X

Core 400 LLC
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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 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.

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INFORMATION PROVIDED TO THE IRO FOR REVIEW: X

PATIENT CLINICAL HISTORY [SUMMARY]: X is an X who was injured on X. X had a work related injury. The diagnoses were postlaminectomy syndrome, not elsewhere classified; long term (current) use of opiate analgesic; spondylosis without myelopathy or radiculopathy, cervicothoracic region and fusion of spine, cervical region. On X, X was seen by X, MD for pain or problems with the neck. X presented for chronic cervical neck pain. X reported that X was about the same with X neck. X reported no other new complaints related to X neck. X was trying to live with X level of pain with reduced medications. X just got X MRI of the lumbar spine and would follow up with X. X continued to have lower back pain. X was working with the X to get further evaluation. X had an MRI of the lumbar spine pending. X was hoping to have someone outside of the X. X had been using some X. X reported X medications were working well. X had X normal aches and pains in different areas around the neck, shoulder and the shoulder blade. X reported that X was managing X pain with X medications. X had X usual neck popping and cracking. X continued X which helped. X had also started X which X believed had helped. X neck pain was helped with X medications. X denied any new numbness or tingling. X continued exercising at home. X reported a lot of grinding, popping and catch. There was no new numbness or tingling. X reported with X medications; X was able to tolerate X daily life activities and chores. X reported improved sleep. The summer was better for X aches and pains. X reported that X medications allowed X to live X life and function. X reported that this work kept X mind good and healthy. That day, X rated X pain as X and pain with medications was rated as X. X stated this problem had affected X ability to work in the normal capacity. The following activities of daily life have been affected: X reported daily house chores, including laundry, dishes, vacuuming, etc. could be done, but X suffered greatly afterwards and required rest to relieve. X sitting tolerance was limited. X could sit for only X-X minutes before needing to stand, walk or lying down. Pain interfered with concentration most of the time. Examination showed pain was reproduced with palpation over the cervical paraspinals and with spinal extension on the left and right sides at X. X was using a X for X lower back pain. X was instructed X. X demonstrated proper compliance and use of X medications There were no signs or symptoms of mis-use or diversion. X were reviewed. X dated X was reviewed and there were no prescription concerns noted. X were continued. X would be considered at the upcoming visit with X. Treatment to date included X. Per a utilization review determination letter dated X, the request for X was denied by X, MD. Rationale: "The Official Disability Guidelines (ODG) state that X. In this case, the claimant's

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history does X. Additionally, there is no documented evidence of X. Furthermore, ODG requires an X. Therefore, the request for X is not supported. "Per a utilization review determination letter dated X, the request for reconsideration for X was denied by X, MD. Rationale: "The Official Disability Guidelines (ODG) state that X. In this case, the claimant's history X. Furthermore, the request for a X. Therefore, the request for reconsideration for X is non-certified. "In this case, the claimant had reported continuing and chronic neck pain. The claimant had X. As of the X evaluation, the claimant had X. The prescription for X. The most recent records in X do not document X. Therefore, it is this reviewer's opinion that medical necessity for the service in dispute: X has not been established and the prior denials are upheld. 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:

In this case, the claimant had reported continuing and chronic neck pain. The claimant had X. As of the X evaluation, the claimant had X. The prescription for X. The most recent records in X. Therefore, it is this reviewer's opinion that medical necessity for the service in dispute: X has not been established and the prior denials are upheld. 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)