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

Sent to the Following

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:

☐ Upheld

☒ Overturned

☐ Partially Overturned

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

- X

PATIENT CLINICAL HISTORY [SUMMARY]:

X who was injured on X. The mechanism of injury was not available in the provided records. The diagnosis was other chronic pain.

On X, X was evaluated by X, MD, for the chief complaint of chronic pain. X presented for a X. The pain was located in the cervical, thoracic, and lumbar spine. The pain was described as radiating, sharp, shooting, throbbing, burning, numbing, tingling, and constant. Worsening factors include prolonged standing, bending, lifting, walking, and other daily activities. X reported mild to moderate pain relief with the X. X denied any side effects or other health concerns at the time. Pain was rated X. On examination, X was in mild distress. Cervical spine range of motion was grossly limited and with pain. Cervical spine inspection revealed X. Thoracic spine range of motion was grossly limited and with pain. Thoracic spine inspection revealed X. Lumbar spine range of motion was grossly limited and with pain. Surgical scar was well healed. Lumbar spine inspection revealed X. X was recommended. The assessment was other chronic pain. UDS from X was consistent. X had X for the neck and low back pain and reported no improvement in managing X daily pain. X was prescribed. X was recommended.

Treatment to date included X.

Per a utilization review adverse determination letter dated X, the request for X was denied by X, MD. Rationale: “The Official Disability Guidelines state that an X may be recommended for lumbar radicular pain when diagnostic imaging correlates with symptoms, pain causes of functional impairment, and when there is X. This procedure is performed under X when there is no bleeding or clotting disorder, and no local or systemic infection. In this case, the claimant has complaints of pain located in the cervical, thoracic, and lumbar spine which is partially relieved with X. A request was submitted for a X. However, there is no recent or updated physician progress report submitted documenting the current symptoms and physical exam findings of the lumbar spine. No imaging was provided to confirm nerve root irritation or impingement. In addition, the specific

level, laterality, and approach of the requested X were not documented. As such, the medical necessity has not been established for the request for X."

Per a reconsideration review adverse determination letter dated X, the appeal request for X was denied by X, DO as not medically necessary. Rationale: "The Official Disability Guidelines recommend X in patients with lumbar radicular pain when diagnostic imaging confirms the diagnosis and correlates with symptoms, pain causes functional impairment affecting activities of daily living, and symptoms have failed to respond to at X. A X is indicated when there is evidence of functional improvement and pain relief of at least X, reassessment of the patient, approach, level, and/or medication has occurred, radicular pain has returned or function has deteriorated since the X, and at least X. In this case, the claimant reports chronic lumbar pain with numbness and shooting symptoms, consistent with radicular involvement, and physical examination demonstrates significantly limited and painful lumbar range of motion with paraspinal tenderness. The provider has recommended a X to address persistent symptoms. However, there is no documentation of diagnostic imaging correlating with radicular symptoms, nor is there evidence that the claimant has completed at least X. In addition, the specific spinal levels to be targeted for X are not identified. 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:

This patient is a X with chronic, multi-level spinal pain from a longstanding occupational injury, with exam findings on X notable for grossly limited and painful range of motion, a well-healed surgical scar consistent with X, and midline and bilateral paraspinal tenderness to palpation - objective findings corroborating X subjective report of radiating, shooting, numbing, and tingling pain consistent with X. X has X. Given X current X pain level despite maximized X. The request for X is medically necessary and therefore the previous denial should be overturned.

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**

☐ **TEXAS TACADA GUIDELINES**

☐ **TMF SCREENING CRITERIA MANUAL**

☐ **PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)**

☐ **OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**