



**MEDICAL EVALUATORS  
OF TEXAS ASO, LLC.**

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**EMPLOYEE CLINICAL HISTORY [SUMMARY]:**

The claimant is a X who was injured on X while X was “X.” New Problem Visit by X PA-C dated X documented had X. The claimant reported X did well after X and only had “increased pain about X. X had become so severe that X presented to the X. They gave X an “X”. The claimant was diagnosed with X.

Final Radiology Report by X, MD dated X documented the claimant underwent an X MRI which revealed a “X. Mild X and X. Mild X. Moderate X. Minimal X . Suggestion of a X at the X. Grade X.”

New Problem Visit by X, DO dated X documented that the claimant returned for a follow up visit regarding X X MRI. The claimant reported “X was at work. X, which is X occupation. X was X. The patient is X performed by the undersigned of the X, and X had recovered completely and was X. Today X reports with pain in the X that persists throughout the day, pain at X, as X cannot X restfully, particularly on the X. X has X. X has had the X as well, and this is affecting X.”

Operative Report by X, DO dated X documented the claimant underwent X.

Progress Notes by X, PA-C dated X documented the continued with X but still had pain with X. Objective findings on examination by X, PA-C included “ X. X. X with pain. Positive pain provocation test. X.X. Distally X. X, PA-C reported “At this point X is not ready to return to work. It appears that X does have some X. I do recommend continuation of X.”

Discharge Summary by X, X dated X documented the claimant had attended X treatments and missed X. X, PT reported the claimant rated X. X, X documented the reason for discharge was the



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claimant had reached maximal level of improvement and there was no indication for further X. X, X reported the claimant was instructed to continue with X.

Prior denial letter from X dated X denied the request for X stating “As per ODG, physical therapy for post-surgical treatment of X... On X, injured worker presented to X OT status post X. The injured worker has been authorized X sessions of X since date of X and continues to complain of pain rated at X. The injured worker has increased pain X, limited X remain decreased. X, PA advised the injured worker has completed X sessions to date and had an X. The injured worker has a follow-up visit X week, where X will be reevaluated after X and the Dr. X will determine if additional X is needed. As such, ODG criteria has not been established and medical necessity cannot be determined. Therefore the request is recommended non-certified.”

**ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE  
CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO  
SUPPORT THE DECISION.**

This is a X who is X.

The records reveal the claimant was approved for X sessions of X, however, only attended X sessions over X weeks. At discharge of X the claimant had X. The claimant reported persistent pain in X. Although the claimant did not attend the X, the physical findings by the treating providers do not substantiate the need for additional X. The claimant's X are reported to be near normal limits and further progress can be made with a X. Furthermore, while the claimant complained of persistent pain, X, PA-C reported the claimant underwent a X. There was no documentation provided that updated the claimant's clinical presentation X.



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Therefore, based on the ODG guidelines and criteria, as well as the clinical documentation stated above, it is the professional medical opinion of this reviewer that the request for coverage of X is not medically necessary and appropriate.

**A DESCRIPTION AND THE SOURCE OF THE SCREENING  
CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE  
DECISION:**

**ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT**