MEDICAL EVALUATORS
OF TEXAS ASO, L.L.C.
2211 West 34th St. ● Houston, TX 77018
800-845-8982 FAX: 713-583-5943

Notice of Independent Review Decision

DATE OF REVIEW: X
AMENDED 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 (Agree)

☒ Overturned (Disagree)

☐ Partially Overturned (Agree in part/Disagree in part)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

X
EMPLOYEE CLINICAL HISTORY [SUMMARY]:
Mechanism of injury:
The claimant is a X who was injured on X in an X. The claimant was diagnosed with X.

2211 West 34th St. ● Houston, TX 77018
800-845-8982 FAX: 713-583-5943

Diagnostic studies:
The claimant underwent an X of the X on X with the following findings: "1.X. 2. X. 3.X. There is also X. 4.X."

Conservative Treatment:
The claimant has been treated with X.

Medications:
The claimant is currently taking X.

Progress notes:
Office Visit Note from X dated X documented the claimant presented with pain in the X. X, MD documented the claimant previously underwent X. The claimant reported a current pain level of X. Dr. X documented the claimant had X. Dr. X recommended the claimant X.

Office Visit Note from X dated X documented the claimant presented with pain in the X.X, PA-C documented the claimant's pain remained X. X documented the claimant had X.

Reason for request:
Prior X dated X denied the request for X is not appropriate and medically necessary for this diagnosis and clinical findings. Official Disability Guidelines conditionally recommends X. Records indicate complains of X; Claimant has history of X. Provider indicated claimant's pain had been previously well managed with X. Based on review, the request is not supported. No documentation of X exam to rule out X. 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.

The claimant is a X who was injured on X in an X. The claimant was diagnosed with X.

Using guidelines from X. The claimant is on X. Documentation reveals the claimant to have had a X. This procedure has been documented to X. The claimant has X.

Based on the referenced guideline and medical literatures, as well as the clinical documentation stated above, the request is medically necessary and appropriate.

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**
□ **AHCPR- 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 JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**

2211 West 34th St. ● Houston, TX 77018
800-845-8982 FAX: 713-583-5943

□ **MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**
□ **MILLIMAN CARE GUIDELINES**

☒ **ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**

X

□ **PRESSLEY 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)**

- X

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