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: 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

INFORMATION PROVIDED TO THE IRO FOR REVIEW
X

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EMPLOYEE CLINICAL HISTORY [SUMMARY]:

Mechanism of injury:
The claimant is a X who was injured on X when the injury occurred when X. The claimant has been diagnosed with a lumbar X. X also has a history of X.

Diagnostic studies:
No documentation of any conservative treatment provided.

Conservative Treatment:
The claimant underwent include X.

Medications:
No documentation of medication treatment provided.

Progress notes:
No documentation of Progress notes provided.

Reason for request:
Prior UR dated X denied the request for X. It was noted that a peer review on X certified the request for X. A preauthorization request letter dated X did not establish that the patient underwent the previously authorized X. Peer discussion was performed with Dr.X. According to Dr.X, the only diagnosis accepted is lumbar X. Although the X was certified, it was not performed as there was no indication for an X. There was an issue with reimbursement for this procedure X was not attempted,
although the medical records did note significant X and the need for X. For this review, the X report indicates that the patient states X. Otherwise, the concerns raised in prior reviews remain relevant. There do appear to be alternative treatment options still available."

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

The claimant is a X diagnosed with a lumbar X. The request is for X.

The guidelines used in this decision recommends the X. A usual treatment X. This includes medication management with an X. If indicated a X. If all X. If X l intervention is not indicated, then a X. Therefore, based on ODG Criteria, as well as the clinical documentation stated above, it is the professional medical opinion of this reviewer that the request X should remain denied as not medically necessary.

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**

☐ **MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**

☐ **MILLIMAN CARE GUIDELINES**

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

☐ **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)**

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

NOTICE ABOUT CERTAIN INFORMATION LAWS AND PRACTICES With few exceptions, you are entitled to be informed about the information that the Texas Department of Insurance (TDI) collects about you.