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
DATE OF AMENDMENT: X

IRO CASE #: X

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

X.

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN 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

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EMPLOYEE CLINICAL HISTORY [SUMMARY]:

Mechanism of injury:
The claimant is a X who was injured on X, mechanism of injury is not addressed in the records provided for review. The claimant was diagnosed with Lumbar Radiculopathy.

Diagnostic studies:
The claimant underwent MRI of lumbar spine which showed X. There is X. Postoperative changes from X. There are X.

Surgeries:
No documentation of any surgeries was provided.

Conservative Treatment:
Medication is reported to provide intended analgesic for pain.

Medications:
The claimant is currently taking X.

Progress notes:
A Clinical summary by X, NP] dated X documented the claimant to have complaints of [back and hip pain that is interfering with walking and X ability to work/walk]. The Objective documents that [X. Pain with lumbar spine motion. X is X on the right.]. The claimant was diagnosed with [chronic pain syndrome,
low back pain, lumbar radiculopathy, and lumbar post-laminectomy syndrome] and [X] was recommended.

Denial Letter:
Denial Letter dated X denied the request for X stating, “it has been determined that the health care service(s) requested does not meet established standards of medical necessity.”

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

The ODG Criteria X

Based on the medical documentation provided, the treating physician documented the utilization of X. The claimant's lumbar spine MRI results indicate clear findings. However, there is X. Furthermore, there is no documentation of the specific level of the X. Therefore, the claimant does not meet the criteria for X. Based on the ODG Guidelines for X, the request is 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**

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

□ **PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR**

□ **TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS**

□ **TMF SCREENING CRITERIA MANUAL**

☒ **PEER REVIEWED NATIONALLY ACCEPTED MEDICAL**

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