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 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

EMPLOYEE CLINICAL HISTORY [SUMMARY]:
Mechanism of injury:
The claimant is a X who was injured on X while X. The claimant was diagnosed with other intervertebral disc displacement of the lumbar region.

Diagnostic studies:
The claimant underwent X. The claimant also underwent a X.

Surgeries:
No documentation of any X was provided.

Conservative Treatment:

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The claimant has been treated with conservative care including physical therapy which is documented that the claimant's pain level increased.

Medications:
The claimant is X.

Progress notes:
Physical Therapy progress notes by X dated X documented the claimant to have complaints X. Objective findings on exam included X. The claimant was diagnosed with low back pain, radiculopathy of lumbar region, and muscle weakness and the continuation of physical therapy treatment per the established plan of care was recommended.

Denial Letter:
The denial letter from TML dated X denied the request for X. "The requested X is not medically necessary. The provider confirmed that there was X. The main complaint was primary axial back pain. Based on this information, the guidelines have not been met for the requested X. Therefore, the requested X is denied."

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION.
Recommended as an option for X. This case lacks any documented instability or significant X. the claimant was diagnosed with other intervertebral disc displacements lumbar region. Based upon this information, the medical necessity has not been met for the X. The decision to deny the requested X is, therefore, upheld.

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

☒ ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES