



Southwestern Forensic
Associates, Inc.

REVIEWER'S REPORT

DATE OF REVIEW: 08/02/08

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

L3/L4, L4/L5 decompression and foraminotomy, instrumentation and fusion at both levels.

DESCRIPTION OF QUALIFICATIONS OF REVIEWER:

M.D., board certified orthopedic surgeon with extensive experience in the evaluation and treatment of the spine-injured patient

REVIEW OUTCOME:

“Upon independent review, I find that the previous adverse determination or determinations should be (check only one):

Upheld (Agree)

Overturned (Disagree)

Partially Overturned (Agree in part/Disagree in part)

INFORMATION PROVIDED FOR REVIEW:

1. SWF forms
2. TDI referral forms
3. Excerpt of denial letter denial letter 06/03/08, denial letter 07/03/08
4. Carrier's records
5. Clinical notes, 07/16/08, 05/19/08, 04/24/08
6. MRI scan of the lumbar spine, 04/22/08
7. Excerpts from the ODG Guidelines

INJURED EMPLOYEE CLINICAL HISTORY (Summary):

This unfortunate female presents with low back pain and left leg pain of many years' duration. A date of injury of xx/xx/xx is reported. No mechanism of injury is documented. There is report of one or possibly two spine surgeries in the past. The

physical examination reveals limited objective physical findings suggestive of radiculopathy. The MRI scan reveals mild to moderate canal stenosis at L3/L4 and L4/L5 as a result of bulging intervertebral discs, hypertrophy of the ligamentum flavum, and facet arthropathy.

ANALYSIS AND EXPLANATION OF THE DECISION, INCLUDING CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT DECISION:

The medical records are inadequate to justify the authorization of the surgical procedure requested. There is no description of the mechanism of injury. There is inconsistency in the history concerning the number of surgeries that have been performed in the past. Nonoperative treatment is not well documented. There is no documentation of epidural steroid injection as might be utilized in the treatment of this patient. There is no psychological evaluation that would be beneficial in deciding whether or not a patient is a suitable candidate for multiple spine surgeries under the Workers' Compensation circumstances. Criteria for approval of fusion surgery as described in the ODG Guidelines have not been met.

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

(Check any of the following that were used in the course of your review.)

- 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 judgment, clinical experience and expertise in accordance with accepted medical standards.
- Mercy Center Consensus Conference Guidelines.
- Milliman Care Guidelines.
- ODG-Official Disability Guidelines & Treatment Guidelines, 2008, Low Back Chapter, Fusion passage
- Pressley Reed, The Medical Disability Advisor.
- Texas Guidelines for Chiropractic Quality Assurance & Practice Parameters.
- Texas TACADA Guidelines.
- TMF Screening Criteria Manual.
- Peer reviewed national accepted medical literature (provide a description).
- Other evidence-based, scientifically valid, outcome-focused guidelines (provide a description.)