



Southwestern Forensic
Associates, Inc.

DATE OF REVIEW: 06/29/08

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Office visit and lumbar spine x-rays on 05/12/08.

DESCRIPTION OF QUALIFICATIONS OF REVIEWER:

M.D., Family Practice physician

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)

Medical necessity is appropriate due to clear pathology in this patient’s lumbar spine and recurrent symptoms as well as prior benefits from previous treatments.

INFORMATION PROVIDED FOR REVIEW:

1. URA Report, May 6 to May 21, 2008
2. Doctor and , ESI Report, May 7, 2007
3. , MD, office notes, September 10, 2004 through May 14, 2008.
4. , MD, RME report, July 19, 2006

INJURED EMPLOYEE CLINICAL HISTORY (Summary):

The employee is an approximately xx-year-old male with a history of a T11 radiculopathy following an injury occurring on xx/xx/xx. He has had several epidural steroid injections with variable results but mostly good. He had recurrent symptoms recently in January 2008.

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

This patient has a prior history of significant disease in his lumbar spine and prior benefit from treatment. It is reasonable to re-evaluate a patient when they have recurrent symptoms, as this patient did. The reason that the visit is necessary is so that the physician, whether it be an orthopedist or primary care physician, may assess whether this is simply a minor recurrence of musculoskeletal symptoms or significant radiculopathy symptoms again. This would dictate different treatments for different diagnoses. Therefore, with a prior significant T11 radiculopathy and prior significant response to appropriate treatment including epidural steroid injections, a patient who is xx years old is appropriate to re-evaluated by the orthopedic surgeon and/or the primary care physician, and x-rays are appropriate to evaluate the nature of these symptoms.

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.
- 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.)