Southwestern Forensic Associates, Inc.

REVIEWER'S REPORT

DATE OF REVIEW: 03/17/08

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
TLIF @L4/5 with PSF, L4/L5 Spinal Monitoring

DESCRIPTION OF QUALIFICATIONS OF REVIEWER:
M.D., Board Certified in Orthopedic Surgery

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

_____Upheld (Agree)

__X __Overturned (Disagree)

_____Partially Overturned (Agree in part/Disagree in part)

INFORMATION PROVIDED FOR REVIEW:
1. Functional Capacity Evaluation dated 04/18/07
2. Chiropractic note dated 05/21/07
3. Initial behavioral health evaluation dated 05/24/07
4. Prescription for discogram from Dr. dated 06/05/07
5. Prescription for program dated 04/24/07
6. Followup note from Dr. dated 06/05/07
7. Psychotherapy certification letter dated 06/12/07
8. Peer-to-Peer Medical Review note from Dr. dated 06/12/07
9. Note from Dr. dated 06/11/07
10. Note from Dr. dated 04/26/07
11. Note from Chiropractic dated 05/29/07
12. Letter from Dr. to Dr. dated 06/12/07
13. Note from Dr. dated 06/11/07
14. Psychotherapy note dated 06/28/07

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15. Note from Dr. dated 05/16/07
16. Letter from Dr. to Dr. dated 04/26/07
17. Psychotherapy note dated 12/27/06
18. Note from Dr. dated 07/17/07
19. Psychotherapy note dated 07/26/07
20. Note from Dr. to Dr. dated 05/12/07
21. Psychotherapy notes dated 08/02/07, 08/09/07
22. Note from Chiropractic and Rehab
23. Environmental Intervention
24. Psychotherapy note dated 10/08/07
25. Note from Dr. Evaluation Center, dated 09/28/07
26. Designated Doctor Evaluation
27. Individual psychotherapy note dated 10/22/07
28. Note from Dr. dated 07/17/07
29. Letter for Designated Doctor Evaluation, Dr. dated 09/07/07
30. EMG study dated 05/16/07
31. MRI scan of the lumbar spine dated 02/10/07
32. Treatment Summary
33. Reconsideration Request dated 09/14/07
34. Note from Dr. dated 01/24/08
35. MRI scan of the lumbar spine dated 02/10/07
36. Notes from Dr. dated 04/04/07 and 03/14/07
37. Functional Capacity Evaluation dated 03/07/07
38. Note from Dr. dated 05/16/07
39. Functional Capacity Evaluation dated 04/18/07
40. Psychotherapy note dated 07/05/07
41. Note from Dr. dated 09/28/07
42. Preauthorization determination for discogram dated 06/11/07
43. Adverse determination of continued physical therapy dated 04/18/07
44. Followup notes from Dr. on 04/26/07, 06/05/07, 01/24/08
45. Adverse determination letters, one dated 01/30/08 with the request for reconsideration letter from Dr. on 02/11/08, and the other dated 02/21/08

INJURED EMPLOYEE CLINICAL HISTORY (Summary):

The patient suffered a work-related injury at multiple levels of the lumbar spine. He failed extensive conservative treatment including anti-inflammatory medications, activity and positional modifications, work modifications, rest, epidural steroid injections, and pain management. Despite continued symptomatology, he was worked up and showed a large stenosis and disc dysfunction at L4/L5. Lumbar decompression and fusion have been recommended but denied.

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

For some reason, the discogram was denied by the insurance company. This would have been helpful. However, it is not necessary. The patient has a large herniated disc at L4/L5 as well as both axial and leg pain. He has failed conservative treatment and fits

the ODG Guidelines for lumbar decompression and fusion. According to ODG Guidelines, the patient meets criteria for lumbar decompression and fusion. There is adequate psychological visits with this patient preoperatively that did not preclude surgery. In addition, there not does appear to be significant psychosocial or medical factors that would interfere with lumbar fusion. The workup and treatment have been appropriate.

DESCRIPTION AND SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE YOUR 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.
__X __Medical judgment, clinical experience and expertise in accordance with accepted medical standards.
_____Mercy Center Consensus Conference Guidelines.
_____Milliman Care Guidelines.
__X__ 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.)

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