



Southwestern Forensic
Associates, Inc.

REVIEWER'S REPORT

DATE OF REVIEW: 04/04/09

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Revision right hemilaminectomy, L5/S1, with transforaminal lumbar interbody fusion at L5/S1.

DESCRIPTION OF QUALIFICATIONS OF REVIEWER:

M.D., board certified orthopedic surgeon with extensive experience in the evaluation and treatment of patients suffering spine injury

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:

INJURED EMPLOYEE CLINICAL HISTORY (Summary):

This female was first evaluated by the current provider on approximately 12/19/07 after having fallen on xx-xx-xx, suffering an injury to the lumbosacral spine. She reported pain in the back with pain radiating into her lower extremity, specifically the right leg. Physical examination demonstrated a positive right straight leg raising test. An MRI scan dated xx-xx-xx revealed L5/S1 intervertebral disc herniation with impingement on the adjacent nerve root. The patient underwent a microdiscectomy laminectomy at L5/S1 on 01/16/08. Postoperatively she initially reported resolution of radicular-like pain. However, she has had persistent low back pain and now has recurrent lower extremity pain. At this time a revision right hemilaminectomy with transforaminal interbody fusion has been recommended as a result of CT scan findings suggesting facet arthropathy. She has reported utilizing a cane to ambulate. Her specific functional capabilities are not consistent. The previous services recommended have been evaluated and primary denial was provided. Reconsideration was accomplished, and the request was denied.

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

The ODG Guidelines, 2009, Low Back Chapter, Lumbar Fusion passage, does not recommend lumbosacral fusion without demonstrated instability. This patient's physical findings are inconsistent. There does not appear to be instability demonstrated that would justify the fusion recommended. An EMG/nerve conduction study is reported to reveal chronic S1 nerve root changes suggesting radiculopathy on a chronic basis. However, the report itself is not provided.

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, 2009, Low Back Chapter, Spinal 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.)