



Southwestern Forensic  
Associates, Inc.

**Amended June 6, 2011**

**REVIEWER'S REPORT**

**DATE OF REVIEW:** 05/25/11

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**

Posterior lumbar discectomy at L4/L5 with decompression of the right L5 nerve root between 5/4 2011 and 7/3/2011; 1 day in-patient hospital stay between 5/4/2011 and 7/3/2011.

**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)

Overturned (Disagree)

Partially Overturned (Agree in part/Disagree in part)

**INFORMATION PROVIDED FOR REVIEW:**

**INJURED EMPLOYEE CLINICAL HISTORY (Summary):**

The patient injured his lower back in his course of employment and suffered a large herniated disc at the L4/L5 level causing significant right L5 nerve root impingement. Despite physical therapy, anti-inflammatory medication and activity modifications, the patient continued to have symptoms many months later. Because of the failure of conservative management, cervical discectomy was recommended. However, the insurance company denied this. The patient initially had pain radicular symptoms. However, the most recent note from the spine surgery indicates motor weakness.

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

The clinical history is obvious in that the patient has a large disc herniation at the L4 nerve root. He has failed conservative management and has progressing neurological deficits with extensor hallucis longus weakness. The insurance company’s doctor stated that physical therapy was not performed. They also stated there was no radiculopathy. However, the records provided to me all demonstrate this, and it also demonstrates a progressive neurological loss. Based on the ODG Guidelines as well as OKU Spine manual, surgery is certainly medically reasonable and necessary and should be approved for this patient.

**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.)