



Southwestern Forensic  
Associates, Inc.

**REVIEWER'S REPORT**

**DATE OF REVIEW:** 12/17/11

**IRO CASE #:**

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

Repeat operation, left L5-S1 foraminotomy

**DESCRIPTION OF QUALIFICATIONS OF REVIEWER:**

M.D., board certified orthopedic surgeon with extensive experience in the evaluation and treatment of patients suffering degenerative disc disease and undergoing lumbar 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:**

1. SWF files
2. TDI referral files
3. Certification page
4. Denial letters, 11/08/11, 10/19/11, and 10/20/11
5. Preauthorization request appeal
6. Case management note, 10/11/11
7. Clinical note, 10/11/11
8. MRI scan of the lumbar spine, 05/16/11
9. Clinical note, 08/30/11, unsigned
10. Injured employee clinical history

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

The claimant is a who sustained an injury to his lumbar spine getting out of his on xx/xx/xx. He sustained a straining injury producing low back pain and left lower

extremity pain. The MRI scan of the lumbar spine on 01/02/08 ultimately lead to a lumbar surgical procedure performed on 06/25/08. The claimant underwent a laminotomy/discectomy at L4-L5 and L5-S1. He underwent a Designated Doctor Evaluation documenting medical improvement and resulting in a five percent whole person impairment rating. He has had a recurrence of symptoms now with recurrence of low back pain and left lower extremity pain. A recommendation to perform re-operation and to perform a foraminotomy at the level of L5-S1 on the left side has been submitted and denied. It was reconsidered and denied.

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

Included in the current medical information is little concerning the recurrence of symptoms of back pain and leg pain. There is little other than the suggestion that a single epidural steroid injection was performed. There is no clear neurological evaluation documented. The justification for re-operation is not clearly documented. The previous denials were appropriate and should be upheld.

**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.)