



Southwestern Forensic
Associates, Inc.

REVIEWER'S REPORT

DATE OF REVIEW: 06/11/12

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

CT scan, cervical spine

DESCRIPTION OF QUALIFICATIONS OF REVIEWER:

M.D., board certified orthopedic surgeon with extensive experience in the evaluation and treatment of patients who have suffered spine trauma

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. Forensic Associates forms
2. Certification of the independence of the reviewer
3. TDI referral forms
4. Letter from attorneys, 05/30/12
5. Denial letters, 05/07/12 and 05/29/12
6. URA records
7. HDI faxes to Forensic Associates
8. Urgent requests for medical records
9. M.D., clinical notes, 08/25/11, 08/03/11, 04/16/12, 02/21/12
10. TWCC-69 form, 07/21/11, 01/05/12
11. M.D., D.D.E evaluation, 07/21/11, including supplemental information, and 01/05/12
12. Patient Support Services fax, 07/28/11
13. Functional Capacity Evaluation, 07/28/11
14. ED confirm letter, 12/07/11

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- 15. Health Systems PT, 05/19/11, 05/05/11
- 16. M.D.

INJURED EMPLOYEE CLINICAL HISTORY (Summary):

The patient is a male who suffered an injury in a slip-and-fall on xx/xx/xx. He has suffered cervical pain and shoulder pain subsequent to his fall. He has a past history of other injuries and a cervical fusion from C4 through C7. He underwent a recent evaluation on 04/16/12 for persistent neck pain and shoulder pain. There is no history of recent injury, and no neurological findings have changed. Prior imaging studies have revealed the postoperative changes from C4 through C7 compatible with solid stable fusion. The prior request for repeat CT scan of the cervical spine was evaluated and denied; it was reconsidered and denied.

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

The examinee has no recent trauma. His plain x-rays reveal no changes in fusion mass. Repeat CT scan does not appear indicated.

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.)