



Southwestern Forensic
Associates, Inc.

REVIEWER'S REPORT

DATE OF REVIEW: 12/02/08

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Physical therapy, twelve sessions, three times a week for four weeks with CPT codes including 97110, 97014, 97010, 97140, and 99070.

DESCRIPTION OF QUALIFICATIONS OF REVIEWER:

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

1. SWF forms
2. TDI referral and forms
3. Denial letter, 10/09/08
4. Denial letter, 10/22/08
5. Requestor records
6. Services memo
7. Performance therapeutic forms and evaluations dated 10/13/08 and 09/28/08
8. Various fax cover pages

INJURED EMPLOYEE CLINICAL HISTORY (Summary):

This unfortunate xx-year-old female fell at work on xx/xx/xx. She suffered an injury to her left shoulder, which has resulted in symptoms suggestive of adhesive capsulitis. She has been treated with medications, local intraarticular injections, and physical therapy, as

well as a manipulation under anesthesia. She has completed an approximate total of 44 sessions of physical therapy. Twelve additional sessions are being requested for preauthorization. The request for additional physical therapy has been denied, and reconsideration has been denied.

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

There is little documentation from the treating provider. This patient has undergone extensive physical therapy and has exceeded the standard recommendation of physical therapy for adhesive capsulitis as published in the ODG. It does not appear that additional physical therapy has much likelihood of providing additional symptomatic relief that has not been achieved to date.

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, 2008, Shoulder Chapter, Physical Therapy 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.)