



Southwestern Forensic
Associates, Inc.

REVIEWER'S REPORT

DATE OF REVIEW: 06/11/08

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Extended occupational therapy.

DESCRIPTION OF QUALIFICATIONS OF REVIEWER:

M.D., board certified orthopedic surgeon with extensive experience in the evaluation and treatment of injured employees

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. Southwestern Forensic Associates forms
2. TDI referral
3. TDI forms
4. Request IRO, 05/20/08
5. Therapy referral for the shoulder
6. Clinic notes, 38 individual notes between 11/20/07 and 04/29/08, which include, M.D., M.D., O.T., and O.T.
7. Denial letter of 05/03/08
8. Denial reconsideration, 05/15/08
9. Requestor records
10. Worker's Compensation First Report of Injury
11. Letter, 05/07/08, requesting reconsideration
12. TWCC-73 forms, nine forms between 01/15/08 and 04/12/08
13. Operative report, 01/17/08

14. Laboratory reports, 01/07/08
15. EKG and chest x-ray, 01/07/08
16. Letter from Senior Care
17. MRI scan, right shoulder, 11/08/07
18. Preauthorization intake form
19. Letter from M.D.
20. Report from D.O., 11/09/07
21. TWCC-73 forms, 09/04/07 and 10/30/07
22. Clinic note, 07/17/07
23. Statement of Pharmacy Services, worksheets, multiple, 02/16/07, 06/14/07, 08/21/07
24. Job description
25. Occupational therapy evaluation, 07/26/07
26. URA records
27. ODG copies from Shoulder Chapter, Procedure Summary, Physical Therapy

INJURED EMPLOYEE CLINICAL HISTORY (Summary):

This unfortunate female suffered two shoulder injuries to the right shoulder. The initial shoulder injury occurred in xxxx and was treated nonoperatively. The current injury occurred on xx/xx/xx and occurred as a lifting/straining injury. She underwent a rotator cuff repair arthroscopically on 01/17/08. The patient has been treated extensively with a combination of occupational therapy and physical therapy subsequent to her arthroscopic procedure. Apparently she is continuing to suffer diminished range of motion and pain.

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

This patient has suffered two shoulder injuries under the Worker's Compensation circumstances. Her most recent shoulder injury resulted in a surgical procedure performed on 01/17/08. Subsequent to the shoulder procedure, she has had extensive physical therapy/occupational therapy, and her diminished range of motion and discomfort persists. It would appear that she has not achieved a benefit from the ongoing physical therapy/occupational therapy. The ODG Guidelines Shoulder Chapter, Procedure Summary, Physical Therapy Criteria include physical therapy after arthroscopic rotator cuff repair to include 40 visits over sixteen weeks. It appears that the patient has exceeded that amount of physical therapy/occupational therapy already without ongoing improvement, which would indicate that she had not yet plateaued.

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, Procedure Summary, Physical Therapy
- 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.)