



Southwestern Forensic
Associates, Inc.

REVIEWER'S REPORT

DATE OF REVIEW: 01/03/09

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Physical therapy.

DESCRIPTION OF QUALIFICATIONS OF REVIEWER:

D.O., Board Certified in Physical Medicine and Rehabilitation, Pain Management

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. I reviewed a request for physical therapy and occupational therapy for left knee and right shoulder dated 11/26/08 from Dr..
2. There was a note from Orthopedic Surgery Group dated 11/20/08. The injured employee was seen for followup. She has not had therapy at this point. She had restricted mobility in the right shoulder due to a proximal humerus fracture and injury to the rotator cuff. There is some pain in her left knee due to the fracture of the kneecap and disruption of the extensor mechanism. She was continuing with her regular work duties. She has restricted mobility of her shoulder with weakness noted. The report was signed by Dr.
3. I reviewed a physical therapy progress note of 11/06/08. The notation indicated that she felt improved motion since the two visits she had previously and notes that she could put her hair up without too much effort without having to flex her neck forward. This was signed by physical therapist .
4. I reviewed an 11/04/08 physical therapy note from, indicating that she had been doing well with physical therapy thus far.

5. I reviewed a re-evaluation note dated 11/04/08 from physical therapist.
6. I reviewed a Peer Review from Dr. He indicated in his notation that the injured employee had already completed 24 sessions of physical therapy as of his review.
7. I reviewed an 11/20/08 report from Dr.
8. There appears to have been a right rotator cuff and greater tuberosity fracture repair on 04/28/08 and open reduction internal fixation of a patellar fracture of the left knee on 04/28/08, although the operative reports are not available.

INJURED EMPLOYEE CLINICAL HISTORY (Summary):

The injured employee is a xx-year-old female who apparently had a work-related injury on xx/xx/xx, although the exact nature of the injury is difficult to discern from the records. Somehow she ended up fracturing her left patella and disrupting the extensor mechanism and also had a proximal humerus fracture with rotator cuff tear. Both of these were surgically corrected, and she completed at least 24 sessions of therapy for those injuries. She has continued to work her regular job. There has been no recent clinical examination to support the need for ongoing therapy above and beyond that which has already been received. Additional therapy beyond the 24 sessions would exceed those recommendations contained in the Official Disability Guidelines. As of mid-November, she still had some functional mobility problems with her right shoulder. However, there was no other comprehensive physical examination of the shoulder identified by her physician. There was very little clinical information available at all with respect to the left knee.

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

The injured employee has had exposure to sufficient quantity of physical therapy for her left knee and right shoulder. There is a lack of current clinical information to support the ODG Guidelines for rehabilitation of the documented right shoulder and left knee injury.

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.
- ___X___ Medical judgment, clinical experience and expertise in accordance with accepted medical standards.
- _____Mercy Center Consensus Conference Guidelines.
- _____Milliman Care Guidelines.
- ___X___ 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.)