Southwestern Forensic Associates, Inc.

REVIEWER'S REPORT

DATE OF REVIEW: 11/11/09

IRO CASE #:
DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Physical therapy at a frequency of once a week for six weeks

DESCRIPTION OF QUALIFICATIONS OF REVIEWER:
D.C. in practice for approximately 30 years, having served as Designated Doctor and as a member of the Medical Quality Review Panel for Texas Workers' Compensation Commission and the Texas Department of Insurance with advanced certification in Manipulation Under Anesthesia, Sports Medicine, and Peer Review

REVIEW OUTCOME:
"Upon independent review, I find that the previous adverse determination or determinations should be (check only one):

__X __Upheld (Agree)

_____Overturned (Disagree)

_____Partially Overturned (Agree in part/Disagree in part)

INFORMATION PROVIDED FOR REVIEW:
I reviewed approximately 57 pages of notes which included but were not limited to:

1. TDI information sent to the IRO, approximately thirteen pages in length
2. Two copies of Utilization Review dated 09/18/09, three pages in length
3. Two copies of Utilization Review dated 10/06/09, three pages in length
4. Two pages of TDI case assignment sent to the IRO
5. One page of fax cover sheet dated 11/02/09, stating that 34 pages were sent
6. Two pages from a company of a preauthorization request dated 09/14/09, two copies
7. Four copies of re-exam report dated 09/03/09, two pages in length
8. Two copies of a request for reconsideration dated 10/01/09
9. Two copies of an initial report dated 07/06/09, four pages in length

INJURED EMPLOYEE CLINICAL HISTORY (Summary):

181 Ruby Lake Drive
Kyle, TX 78640
512.504.3288 * 512.697.8301 (fax) * Email: nan@swforensics.com

The patient is a male who was injured when he ran to the van to grab a part. He slipped and fell backwards, hitting his head and breaking the fall with
what looks like his right upper extremity. He then went to a local emergency room where he was evaluated, treated, and released after being given an intramuscular injection and a prescription for Vicodin, Flexeril, and ibuprofen.

ANALYSIS AND EXPLANATION OF THE DECISION, INCLUDING CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT DECISION:
As stated sufficiently in the Utilization Review response, the ODG does not support physical therapy at a frequency of once a week for six weeks at a point approximately xxxx post injury. The patient has been undergoing some home exercises. The utilization review physician also notes that on the subsequent re-exam report dated 09/03/09, there were no indications to support more therapy. To quote the doctor's own report, "The upper extremity neurological examination is grossly normal with regard to dermatomal sensation, deep tendon reflexes, and muscular strength." The only other positive sign was a left shoulder depression and some tenderness and hypertonicity to the left cervical and upper thoracic area.

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 and chiropractic 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.)

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