



Southwestern Forensic  
Associates, Inc.

**REVIEWER'S REPORT**

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**

Continued physical therapy, three times a week for four weeks including CPT codes 97010, 99701, 97014, 97035, 97124, 97140, 97530, 97116, 97113

**DESCRIPTION OF QUALIFICATIONS OF REVIEWER:**

M.D., board certified orthopedic surgeon with extensive experience in the evaluation and treatment of patients suffering knee 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 forms
3. Denial letters, 03/11/10 and 03/30/10
4. Therapy referral, 02/23/10
5. Clinical notes, 02/23/10, 02/16/10, 03/02/10 04/22/10, 03/23/10, 01/19/10, 01/05/10, 10/07/09, and 10/06/09
6. Multiple fax cover sheets
7. Functional Capacity Evaluation, 04/09/10
8. MRI scan, 09/28/09

**INJURED EMPLOYEE CLINICAL HISTORY (Summary):**

The patient is a male who suffered an injury when he fell into a trench, twisting his left knee on xx/xx/xx. His initial treatment was via physical therapy. He underwent MRI scan and has undergone arthroscopic procedures on at least two occasions and has undergone physical therapy after each. Currently the patient has a recommendation for additional physical therapy, which has been considered and denied, reconsidered and

denied. A Functional Capacity Evaluation subsequent to the denials of the request for additional physical therapy demonstrated weakness in the left lower extremity which resulted in a recommendation for a work hardening program.

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

This patient has received the recommended physical therapy regimen post arthroscopic meniscectomy. He has persistent weakness, however, the general physical therapy program requested does not appear to include sufficient strengthening modalities to warrant its approval.

**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, Cervical Spine Chapter, Discography 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.)