



Southwestern Forensic
Associates, Inc.

REVIEWER'S REPORT

DATE OF REVIEW: 08/30/11

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Physical therapy at a frequency of three times a week for four weeks

DESCRIPTION OF QUALIFICATIONS OF REVIEWER:

D.C., practicing for approximately 30 years in the field of Chiropractic.

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)

INJURED EMPLOYEE CLINICAL HISTORY (Summary):

This is a male who fell on ice after leaving work. It was reported that he slipped and his feet went out and he landed on the back of his head, upper shoulders, and back. He also briefly loss consciousness and later had lightheadedness and headaches.

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

In the initial report from Clinic dated 02/04/11, the presentation of the history stated that the patient slipped and his feet went out from under him, landing on the back of his head, upper shoulders, and back in that order. He briefly loss consciousness and later had lightheadedness. First, since he described that he fell on his shoulder, it is not unreasonable to assume there is also some pain in his shoulder.

The report from D.C., on 08/17/11, states that the left shoulder was not part of the compensable injury. Dr. further delineates several of the criteria that he used, which we will be using, as well, including but not limited to the ODG Guidelines, the Guidelines for Chiropractic Quality Assurance and Practice.

However, an initial report from Worker's Clinic notes that the patient reported he had persistent pain in his left shoulder and reported that to Dr. his primary care physician he is seeing for his diabetes mellitus. It is also noted that Dr. ordered an MRI scan from

City, which showed a rotator cuff tear of the left shoulder with full thickness tear. The care requested is found to be reasonable and necessary.

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.
- 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.)