Specialty Independent Review Organization

Date notice sent to all parties:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

The item in dispute is the prospective medical necessity of physical therapy XX x Wk. x XX Wks. for the XX XX area.

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:

The reviewer is a Medical Doctor who is board certified in Orthopedic Surgery.

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

☒ Upheld (Agree)

☐ Overturned (Disagree)

☐ Partially Overturned (Agree in part/Disagree in part)

The reviewer agrees with the previous adverse determination regarding the prospective medical necessity of physical therapy XX x Wk x XX Wks for the XX XX area.

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a XXXX who was injured on XXXX. The claimant was diagnosed with a XX strain. An MRI on XXXX, documented normal XX with no compression XX or XX process. There was XX% narrowing of the XX-XX disc with disc height adequately maintained at all other XX levels. There was a XX mm XX XX at XX-XX. The adjacent XX neural XX and exiting nerve roots were adequately maintained. There was a XX mm XX XX at XX-XX with XX% XX along the XX margin of the XX sac. The adjacent XX and XX XX and exiting nerve roots were adequately maintained. At XX-XX there was a XX mm XX XX with XX% effacement along the XX margin of the XX sac. The XX XX and exiting nerve roots were adequately maintained. At XX-XX there was a XX mm XX XX with predominance along the XXXX XX margin with XX% XX along the XX margin of the XX sac. At XX-XX there was a XX mm XX XX with XX% XX along the XX margin of the XX XX and of the XX XX XX

along the XX margin of the XX exiting nerve root in addition to the XXXX XX XX along the XX margin of the XX nerve root. At XX-XX there was a XX.XX mm XX to the XXXX of XX with XX% XX along the XXXX XX margin of the XX sac. The XX XX XX was XX% XX along the XX margin of the exiting XX XX. There was XX% XX noted on the XXXX. Treatment had included physical therapy and medication. An evaluation in physical therapy was initially performed in XXXX. An evaluation on XXXX, documented exacerbation of symptoms. There was pain radiating into the XXXX XX with reports of pain of XX/10 on a Visual Analog Scale with medication and XX/10 on a Visual Analog Scale without medication. Forward flexion was XX degrees, extension was XX degrees, XX XX flexion was XX degrees, and XX XX tightness was present. Pain was noted on forward flexion. Overall strength was XX/5 in the XX XX XX. Ambulation was without assistive devices. The claimant was XX with XX-XX, XX XX, and XX. There was fair tolerance to bending and prolonged postures. Physical therapy progress notes were provided from XXXX noting XX sessions completed.

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

The guidelines would support XX physical therapy sessions. The claimant has had at least XX, if not more, physical therapy sessions to date. The majority of XX XX injuries typically resolve in XX to XX weeks. The most recent objective physical examination findings would not support the medical necessity to exceed guideline recommendations. There was not documentation of specific functional deficits to support the request nor was there mention of re-injury. The request for physical therapy XX times a week for XX weeks to the XX XX is not certified.

Official Disability Guidelines Treatment Integrated Treatment/Disability Duration Guidelines XX XX (XXXX) Physical therapy (PT) Recommended. There is strong evidence that physical methods, including exercise and return to normal activities, have the best long-term outcome in employees with XX XX pain. See also Exercise. ODG Physical Therapy Guidelines – Allow for fading of treatment frequency (from up to XX or more visits per week to XX or less), plus active self-directed home PT. XX sprains and strains: XX visits over XX weeks.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

☐ **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 JUDGEMENT, 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 NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)**

☐ **OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**