CASEREVIEW

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

XX Visits/XX weeks of physical therapy to the XX XX leg to include XX (Therapeutic exercises); XX (XX therapy); XX (Neuromuscular re-education)

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

This physician has over 19 years of experience in Physical Medicine and Rehabilitation.

**REVIEW OUTCOME:**

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

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

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

**PATIENT CLINICAL HISTORY [SUMMARY]:**

XXXX

On XXXX, the claimant presented to XXXX for XXXX XX physical therapy visit. It was reported XXXX had reached XX% of XXXX goal by this visit. Recommendations: Much discussion was had about rehab moving forward and what the MRI could possibly show. The pt was eager to know the results. The pt had been able to progress well through physical therapy, however was still very limited with XXXX impairments as well as it appeared to be a further injury to the HS. This would not be definitive until the MRI results. Return to referring physician.

On XXXX, the claimant underwent a XX XX XX Epidural Steroid Injection.

On XXXX, the claimant presented to XXXX with XX% improvement from the XX XX XX epidural steroid injection. XXXX denied any progressive XX, or problems from the injection. XXXX was still working XX days a week, kind of XX days. When does have a lot of bending, lifting, twisting, and walking up and down, XXXX XX leg would start to bother XXXX, XX thigh and calf area with XX and XX. XXXX reported not getting the XXXX. On exam XXXX straight leg raise at XX degrees induced XX thigh to midway to calf with XX. No XX. Assessment: XX-XX XX XX, XX recess XX with XX EMG findings. Plan: Post-injection therapy for XX visits, XXXX at night. Continue with home-exercise program.

On **XXXX**, the claimant presented to **XXXX** XX for evaluation of post injection physical therapy. Physical therapy was recommended, XX for XX weeks.

On XXXX performed a UR. Rationale for Denial: According to the Official Disability Guidelines XX XX Chapter, XXXX: Physical therapy (PT) section was referenced for this request. The injured worker was previously non-certified a course of physical therapy on XXXX. The injured worker has completed XX sessions of physical therapy as of XXXX. The guidelines recommend up to XX sessions of physical therapy for this patient's condition. The number of sessions requested is well beyond that recommended by the guidelines. Additionally, the medical report dated XXXX, does not establish significant objective functional improvement from the previous course of physical therapy. Furthermore, the injured worker should be able to transition to an independent home exercise program at this time.

On XXXX performed a UR. Rationale for Denial: Based upon the available documentation for review, and the included noted guidelines, this reviewer respectfully does not recommend approval for the requested services as reasonable or medically necessary. The request exceeds guidelines criteria for number of visits (XX). The injured worker is status post at least XX sessions of formalized therapy. No report of acute functional deterioration or acute injuries is provided. No report regarding type and extent of objective functional gains from past formalized therapy is documented. This reviewer does not appreciate extenuating circumstances to support the need of exceeding the number of recommended formalized therapy sessions with additional therapy versus the use of a daily home exercise program.

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

Determination: denial of XX Physical Therapy visits over XX weeks is PARTIALLY OVERTURNED with medical necessity of XX PT visits over XX1 week in accordance with ODG so as to capitalize on XX% improvement after Epidural Steroid Injection and to update a Home Exercise Program.

**PER ODG:**

XX

**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)**