Medical Assessments, Inc.

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DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Physical Therapy XX week for XX ankle

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
The Reviewer is a Board Certified Orthopedic Surgeon with over 15 years of experience, and is fellowship trained in adult spine surgery.

REVIEW OUTCOME:

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

☒ Upheld (Agree)

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]:
The claimant is a XXXX with a history of XX claim dated XXXX.

XXXX: X-ray XX by XXXX. Impression: No acute findings. Findings: XX, XX and oblique views of the XX XX. No fractures, dislocations, XX or blastic lesions are appreciated. Joint spaces have normal appearance.

XXXX: Office visit by XXXX. Claimant reported that XXXX was able to into XX XX for longer than XX hours, however, there was an increase in symptoms when attempting to continue this progression closer to XX hours. The claimant reported minimal pain using a XX XX and certain XX. Focused evaluation of the XX XX XX found pain mostly in the XX XX joint area of the XX XX XX toe with some mild XX and patient had XX pain at the XX XX joint and no pain during a ROM. The pain at that time was for PT.

XXXX: UR performed by XXXX. Rationale for denial: The current request is for PT XX for the XX ankle. Determination – non-certified.

XXXX: UR performed by XXXX. Rationale for denial: The XXXX office visit summary of the XXXX examination noted that the claimant had new x-ray taken and revealed a XX foot XX XX fracture that had healed, but the claimant had continued pain. The claimant had undergone prior PT and was taking XXXX for pain. The pain was rated XX-XX/10. The claimant had been gradually able to get into XX XX for longer than XX hours but had increased symptoms as XXXX progressed closer to XX hours. XXXX continues to XX XX. The providers plan was to return the claimant to work with a modified work schedule recommend PT and progressively increase XXXX XX-XX activities. On XXXX PT was denied as XX visits exceed guideline recommendations. The request for PT of the ankle is not supported. Request for PT XX weeks for the XX ankle is non-certified.

ODG Physical Therapy Guidelines –
XX

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

The request for XX sessions (XX/week for XX weeks) of physical therapy is denied.
This patient sustained a XX of XXXX XX XX XX XX (XX) joint in XXXX. XXXX recent radiographs demonstrate no abnormalities of this joint. XXXX continues to have pain and XX in this region, despite medication. XXXX has difficulty wearing a XX more than XX hours. The treating XX has recommended XX sessions of physical therapy.
In accepted practice, XX sessions of therapy is appropriate for this type of injury. The patient is re-evaluated before additional therapy is considered.
The request for XX-XX sessions of therapy is not the standard of care. It is not medically necessary for this patient.

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)**