Vanguard MedReview, Inc.

101 Ranch Hand Lane
Aledo, TX 76008
P 817-751-1632
F 817-632-2619

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DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

XX sessions of physical therapy for XX and XX XX

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

This case was reviewed by a Board-Certified Doctor of Physical Medicine and Rehabilitation with over 20 years of experience.

REVIEW OUTCOME:

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

☒ Overturned (Disagree)

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. **HPI:** The patient is a XXXX who came to the XX XX after a near XX episode with XX to the XX and XX. The patient had gotten in XX XX XX and XX XXXX XX XX medications and then again XX XX XX XX XX and took XXXX XX XX medications again to get back on XXXX regular schedule. However, the patient had an episode of near XX and XX. XXXX had recent change in medications. XX XX pressure and XX XX upon admission. The patient has associated XX of XX, XX XX disease, XX XX, and XX XX disease. Past XX history: Previous admission to XXXX. XXXX had XX showing XX fraction of XX%. Chambers are normal. There is concentric XX ventricular XX. There is no pericardial XX. There is trace XX XX. Current meds: XXXX. Allergies to XXXX. **Physical Exam:** Decreased rate and regular rhythm. The patient is in no acute distress. Patient has an XX on bridge of XXXX XX. **Impression:** 1. XX. 2. XX. 3. XX. 4. History of XX disease. 5. History of XX XX disease. 6. History of XX. **Plans:** 1. Observation. 2. Evaluate for XX XX with serial XX. 3. XX to evaluate XX XX function. 4. We will adjust the patient's XX XX meds.

XXXX. **Impression and Plan:** Near XX, XX, XX induced. XX due to medication. Admit.

XXXX. **Procedure:** Tilt table test. **Preoperative Diagnosis:** XX secondary to XX causes. **Assessment:** 1. XXXX. 2. XXXX. 3. Benign essential XX. 4. XX with loss of XX, sequel. 5. Low XX. 6. Infection of XX. **Impression:** XXXX had an excess of XX meds, causing XX to XX, causing XX which lead to a XX with XX. XXXX is to hold meds at XXXX until XXXX sees XX. XXXX is not to work until cleared, XXXX is XX XX about this. XXXX. Follow up one week.

XXXX. XXXX states XXXX XX, XX, and XX is worsening. Continue to monitor.

XXXX. **HPI:** Patient presents XXXX. XX and XX. XX for XX days and placed on XX monitoring. CT negative. Sees XXXX for XX XX injury/ pain management for XX and XX. XXXX has ESI. Stated XXXX has XX pain and XX. XX XX bothers XXXX with activity. **Exam:** Upper extremity: XX (XX, XX, XX, XX, ROM (diminished, XX, XX, flexion), Impingement tests (Negative (XX))), hand (XX, tenderness, XX hand XX tender and mild XX XX XXaspect.). XX/XX: XX (XX, tenderness, ROM (diminished, passive, flexion, XX) XX XX trap folds). XX extremity: knee (XX, XX, ROM (XX, passive flexion)). Radiology: XX hand XX v no fracture or acute bony defects. **Impression/Plan:** Unspecified injury of XX, initial encounter. Sprain of XX of XX XX, initial encounter. XX sprain. XX of XX hand. XX without XX of consciousness, initial encounter. Plan: apply heat

XXXX: Nerve Conduction Study by XXXX. **Interpretation:** XX XX XX. At this time, the patient with active ongoing XX potential XX XX XX. There is no significant evidence of chronic XX but does have significant evidence of ongoing XX.

XXXX: Office Note by XXXX. **HPI:** Patient presents following XX injury. About the same. XX XX. XXXX did not help. Unable to XX XX. Saw pcp and prescribed meds but not approved by carrier. c/o XX/XX knee and XX pain. Problems with XX/XX. Light XX. XX on and off but have been decreasing. No problems with balance or coordination. XX tense. **Impression/Plan:** Unable to return to work due to XX XX. Follow up with ortho for XX XX and XX injury.

XXXX: MRI of the XX pre and post intravenous contrast interpreted by XXXX. **Impression:** Unremarkable MRI of the XX except for trace XX XX XX thickening.

XXXX: Office Note by XXXX. **HPI:** Patient has problem reaching and grabbing. XX XX still painful. To see ortho for XX injections. Also ortho for XX. Sees pain management for XX and XX pain.

XXXX: Office Note by XXXX. **HPI:** XXXX is having treatment on XX XX XX from pain management. Has follow up with ortho XX XX and XX XX pain. Has been XX a XX in XXXX XX knee.

XXXX: C-XX w/o + MRI XX-XX w/o interpreted by XXXX. **Impression:** Multilevel XX changes are seen throughout the XX XX and described in detail at teach level in the body of the report. XX post XX XX fusion and XX from XX-XX. The XX construct is well aligned. XX 1

XX XX of XX on XX. Central XX XX of the XX XX is present worse at XX-XX and XX-XX as described in the body of the report. There is no MRI evidence of XX cord XX. No mass. No MRI evidence of XX XX injury.
Multilevel XX changes are seen throughout the XX XX with XX, central XX XX, XX XX. The findings are described in detail at each level in the body of the report. Benign XX is present in the XX body of XX. Central XX XX present at XX-XX, XX-XX XX-XX.

XXXX: Initial Evaluation by XXXX. Patient is XX complaining of XX and XX gait as well as XX stabilization and XX/XX issues status post XXXX. XXXX has signs of XX as well as central XX XX status post-XX. Due to prolonged period since injury, and not having therapeutic intervention, XXXX has good to fair prognosis to reach prior level of function.

XXXX: Office Note by XXXX. **HPI:** Other providers have released XXXX. They are not XX providers. PT has helped.

XXXX: Office Note by XXXX. **HPI:** The patient was referred to me for evaluation of multiple areas of pain. XXXX is a XXXX. About XXXX year ago, XXXX was injured in XXXX XX, knee and XX. XXXX had MRI, nerve testings and injection at XXXX XX and XX area. After injections, XXXX pain improved for weeks, but came back again. Because XXXX had multiple area pain, today XXXX agreed to discuss XXXX XX XX pain mainly. XXXX got PT for XX, but XXXX did not get PT for pain. Pain is XX. **Exam:** LE XX XX Hip flexion XX+/5 knee extension XX/5 ankle dorsiflexion XX/5 long toe extension XX+/5 ankle plantar flexin XX/5. XX side XX flexion XX+/5 knee extension XX/5 ankle XX XX/5 long toe extension XX+/5 ankle plantar flexion XX/5. Sensory: temperature/vibration sym, XX. XX XX+++/++ XX +++/++, pathologic reflex ankle clonus XX Babinski sign XXXX cerebellar sign: XX sym intact. Gait: XX. Kemps+ Tenderness on bilateral XX XX muscles/XX joint. SLR test: XX. Patrick test: XX. XX compression and distraction: XX. Gaenslen test: XX. Fortings finger test point: pinpoint at XX XX area. **Impression/Plan:** XX XX XX XX, chronic XX pain, XX XX, XX XX. The patient has multiple XX of pain. Currently XXXX XX XX pain is the XX. The majority appears to be XX related. However, it is unclear what procedures XXXX has had done in the past. XXXX has also not failed conservative management with PT. We will start PT for XX XX pain and XX pain. F/U XX-XX weeks.

XXXX: Disability Determination Letter by XXXX. **Diagnosis:** 1. Traumatic XX XX/XX/XX XX. 2. XX and impaired XX XX bilaterally. 3. XX knee XX. 4. XX/XX strains. 5. XX hand XX. 6. XX pain. 7. XX XX pain. 8. XX XX XX XX. 9. Status/post anterior XX XX and XX XX-XX in XXXX with adjacent segment XX disease, preexisting. 10. XX XX XX XX with multilevel XX, preexisting. 11. Grade XX XX XX XX-XX. The examinee has several issues secondary to XXXX XX XX injury. XXXX is just beginning to determine the extent of XXXX injury. XXXX has an appointment with a XX. Anticipated improvement is in XXXX. This is dependent on extent of XX XX primarily.

XXXX: UR performed by XXXX. **Rationale for Denial:** Based on the medical records submitted for review, XX sessions of physical therapy for XX and XX XX are not recommended. Patient has had XX physical therapy sessions to date. Per ODG, patient should be able to perform active home exercise program at this time. Date of injury was XXXX. There is

no medical indication for physical therapy at this time.

XXXX: UR performed by XXXX. **Rationale for Denial:** This is a non-certification of a request for reconsideration of XX sessions of physical therapy to the XX and XX XX. The previous non-certification on XXXX was due to lack of medical necessity. The previous non-certification is supported. Additional records were not submitted for review. The guidelines would support XX physical therapy sessions over XX weeks. The claimant has undergone XX physical therapy sessions. There was not objective documentation of improvement with the physical therapy to date to warrant additional physical therapy. An objective physical examination was not provided on the most recent progress note provided for review. The request for reconsideration of XX sessions of physical therapy to the XX and XX XX is not certified.

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

Determination: denial of XX Physical Therapy visits is OVERTURNED/DISAGREED WITH since review of the XX PT notes from **XXXX** document XX Rehabilitation for diagnosis of XX but do not document any exercises to specifically address diagnoses of XX and XX XX Pain, and there is no documentation of instruction in a home exercise program for the XX and XX XX. There is recent documentation in a PT evaluation on XXXX of XX and XX XX Range of Motion XX. Therefore, the requested XX PT visits for the XX and XX XX are medically reasonable and necessary and in accordance with ODG for the submitted diagnoses. 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)**