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DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Additional XX visits over XX weeks of XX therapy for the XX XX

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

Orthopaedic Surgery

REVIEW OUTCOME:

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

☐ Overturned	Disagree
☐ Partially Overturned	Agree in part/Disagree in part
☒ Upheld	Agree

PATIENT CLINICAL HISTORY [SUMMARY]:

XXXX who was diagnosed with XX of XX XX of the XX XX (XX.XX). On XXXX, XXXX and had XX XX XX. Per the report dated XXXX, XXXX. XXXX experienced pain and XX in the XX and XX of the XX XX. On XXXX where XXXX primary complaint was XX and XX XX pain. The pain was worse on the XX XX XX area. On the day, XXXX reported that XXXX XX XX was feeling better due to being off of XXXX feet recently. The weightbearing status was full weightbearing with a XX XX. XXXX could put more weight through the XX XX XX without pain. XXXX had XX. The XX XX and XX examination showed mild-to-moderate XX and XX XX on the XXX joint. The range of motion showed XX pain with XX degrees of XX, XX degrees of XX, XX degrees of XX XX and XX degrees of XX XX. There was mild-to-moderate pain with XX motion. The range of motion was XX limited. Single XX raise was with XX difficulty, exhibiting pain and weakness. XXXX was XX a XX XX all the time. Treatment to date consisted of medications (XXXX), XX therapy (with improvement) and XX XX. Per a utilization review determination letter dated XXXX, the request for additional XX visits over XX weeks of XX therapy for the XX XX was denied. It was determined that the available documentation indicated XXXX sustained an injury on XXXX and had been diagnosed with XX

XX XX. It was reported that XXXX was able to fully weight-bear with the XX of a XX XX and had completed approximately XX XX therapy visits thus far. The most recent XX therapy visit on XXXX demonstrated XX-to-XX tenderness in the XX joint, mild XX, and mildly painful XX and XX XX. There was no documented objective evidence that the previous trials of XX therapy had provided functional XX. The complaint was over XX months old and was not clear why additional XX therapy was necessary. Official Disability Guidelines recommend XX therapy for foot XX and XX XX syndrome between XX-XX sessions and allow for fading of treatment frequency, plus active self-directed home XX therapy. The request would exceed the recommendations of the guidelines; therefore, based on the lack of submitted documentation and guideline support, the request was not certified. On XXXX had a XX-week follow-up visit with XXXX for the XX XX XX sprain. XXXX had recently completed XX therapy and had continued XX XX weightbearing and was feeling better than XXXX prior visit. XXXX had minimal pain but was overall doing well. The pain was rated as XX/10. The XX XX and XX examination were non-significant compared with the previous examination. Return to work was planned on XXXX. A utilization review determination letter dated XXXX indicated that within the associated medical documentation, XXXX was diagnosed with XX XX XX of the XX XX. In addition, there was documentation of XX previous XX therapy treatments completed to date and objective improvement with previous treatment. Objective findings included no XX or XX, normal XX strength, and normal XX. The plan was to return to work on XXXX. There was no documentation of functional deficits and functional goals. The requested additional XX visits over XX weeks of XX therapy for the XX XX in addition to the XX XX therapy treatments completed to date, would exceed the recommendations of the guidelines, therefore, the reconsideration request for additional XX visits over XX weeks of XX therapy for the XX XX was non-certified.

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

The documentation available indicates that this XXXX sustained a XX XX XX. The documentation goes on to indicate that XX additional XX therapy sessions were ordered after the initial completion of XX sessions. The recent clinical progress notes indicate minimal pain with no strength and range of motion deficits and a plan to return to work. It is unclear why further therapy would be required given the lack of significant deficits and when noting that the only abnormal finding was minimal pain. As such, the prior utilization reviews which recommended noncertification of the additional XX therapy which would exceed the ODG recommendation XX-XX sessions would be considered reasonable and consistent with the clinical standard of care and guideline recommendations. The reviewer's medical assessment is to recommended upholding the previous denials. Given the documentation available, the requested service(s) is considered not medically necessary and the decision is upheld.

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

☐ AHRQ- 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

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

☐ PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

☐ PRESLEY REED, THE MEDICAL DISABILITY ADVISOR

☐ TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

☐ TEXAS TACADA GUIDELINES

☐ TMF SCREENING CRITERIA MANUAL