MedHealth **R**eview, **I**nc.
661 E. Main Street
Suite 200-305
Midlothian, TX 76065
Ph 972-921-9094
Fax (972) 827-3707

DATE NOTICE SENT TO ALL PARTIES: 12/10/18

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The item in dispute is the prospective medical necessity of physical therapy XX/week for XX weeks as an outpatient S/P XX for XX XX fracture and XX removal on XXXX.

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

The reviewer is a Doctor of Podiatric Medicine who is board certified in Podiatric Medicine. The reviewer has been practicing for greater than 10 years.

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 disagrees with the previous adverse determination regarding the prospective medical necessity of physical therapy times XX visits.

The reviewer agrees with the previous adverse determination regarding the prospective medical necessity of physical therapy times 6 visits.

PATIENT CLINICAL HISTORY [SUMMARY]:

XXXX. XXXX performed surgery on the ankle on XXXX and the patient presents with continued pain and XX to the office of XXXX. XXXX XX history includes XXXX. Exam findings indicate reduced ROM both passively and actively with mild XX. Also noted was slight instability with XX XX and ankle XX. Radiographs were essentially within normal limits. The surgical report of XXXX indicates the painful XX was removed from the XX XX XX. XXXX was seen again on XXXX by XXXX with the following recommendations of aggressive physical

therapy, beginning to wear XXXX regular shoes, and perform normal ADLs. The Plan of Care notes on XXXX indicate the injured worker has reduced ROM and strength on the involved side. The XXXX report by XXXX indicates that XXXX felt some PT was necessary but could not modify the request for XX visits; therefore, it was denied. XXXX also opined that some PT was necessary after the second surgery but was unable to modify the request as well. The XXXX office note by XXXX indicates similar findings as before. XXXX, no PT visits are discussed in the records provided.

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

Physical therapy is a time honored and evidence-based treatment for post-surgical treatments. Upon review of the ODG's foot and ankle documents, there is no specific mention in the physical therapy section about hardware removal; however, there are XX mentions of this procedure in the document. ODG recommends removal in situations such as broken pins, exposed XX, or persistent pain after ruling out other causes of pain such as infection and nonunion. This was done on XXXX and the closest match in the ODG PT section is in regard to medical treatment of a closed ankle fracture which indicates 12 visits over 12 weeks. Therefore, based upon the patient's presentation, previous treatments, and evidence-based medicine guidelines, XX PT visits are medically necessary for this case. The remaining XX visits are not medically necessary as the reviewer feels that these would not likely cause increased function greater than would a home-based therapy protocol taking place after the approved therapy sessions.

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)**