AccuReview

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December 18, 2018

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Physical/Aquatic Therapy XX, totaling XX sessions

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

This physician is Board certified in Rehabilitation and Physical Medicine with over 23 years of experience.

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]:

XXXX: Pain Management Consult Note dictated by XXXX: XXXX with chronic XX pain from previous XX surgery and post op XX. XXXX has an XX XX style XX system in place since XXXX, initially working well but now switching to a XXXX XX. XXXX pain management specialist is requesting a XX style lead. XXXX arrived for XX, reported partial pain control with medications XXXX for XX pain. Assessment: XX XX syndrome. Plan/Recommendations: XX XX syndrome XX placement of XX XX XX lead via XX XX. XXXX mf XX times daily. XXXX every XX hours XX severe pain. Encouraged to optimize XX as needed and XX regimen.

XXXX: Office Visit dictated by XXXX. CC: XX pain, chronic pain. XX XX: XX moderate and XX XX XX with XX. XXXX pain with extension and rotation ROJM, XXXX pain with extension and rotation. Pain refers to XX on affected side, pain refers XX to XXXX XX XX and pain refers XX to XXXX XX XX. Significant XX to palpation over XX XX joints above XX. Assessment: XX XX syndrome XX, other XX episodes XXXX, long term use of XX analgesic XX.XX, XX XX of XX region XX.XX, chronic use of XX drugs therapeutic purposes XX.XX, disc XX, XX XX.XX, XX XX stimulator status XX.XX, XXXX, chronic XX XX XX.XX, fall, XX W19.XXXS, acute pain of XXXX knee XX.XX. Treatment: Continue XXXX. While short term use may be indicated, long term goal would be to wean off XX. Comprehensive pain management approach would include physical therapy, acupuncture, chiropractic care, pain XX, interventional procedures, and neuropathies. Obtain x-ray for knee s/p fall for pain and XX. RTC XX weeks.

XXXX: Operative Report dictated by XXXX. Pre-op Diagnosis: XX XX syndrome. Post-op syndrome: same as pre-op diagnosis. Operation: XX pain XX XX, analysis, and reprogramming. Ultrasound guidance.

XXXX: Office Visit dictated by XXXX: XX pain, chronic pain. PE: XX: XX XX joints: XX and pain with ROM of XXXX knee. XX XX: Inspection and Palpation: XX moderate and XX XX XX with XX. XXXX-pain with extension and rotation. XX – XXXX: pain with extension and rotation. Pain location refers to XX on affected side, pain refers XX to XXXX XX XX and pain refers XX to XXXX XX XX. Significant tenderness to palpation over XX XX joints above XX. Assessment: XX pain XX XX.XX, other XX episodes XX.XX, long term use of XX XX XX.XX, XX XX of XX region XX.XX, chronic use of XX XX therapeutic purposes XX.XX, disc XX, XX XX.XX, XX XX stimulator status XX.XX, XXXX, chronic XX XX XX.XX, fall, XX W19.XXXS, acute pain of XXXX knee XX.XX. Treatment: Stop XXXX due to doing much better with the XX pain XX. Claimant is a candidate for XX of XX. XXXX has been much more active but cannot XX, will adjust the XX to XX percent during the day and XX% at night. Discussed XX pain XX XX in the office today and the claimant is interested in processing. XXXX was scheduled for an XX trial to determine whether a permanent XX is warranted, XXXX had over XX% relief.

XXXX: Operative Report dictated by XXXX. Pre-op Diagnosis: XX XX syndrome. Post-op syndrome: same as pre-op diagnosis. Operation: XX pain XX refill, analysis, and reprogramming. Ultrasound guidance.

XXXX: Daily Aquatic Therapy dictated by XXXX. XX pain XX/10. Claimant able to complete all exercises per flow with increased pain or difficulty. XXXX had good response to XX XX degrees decreased pain, and progress as able.

XXXX: Daily Aquatic Therapy dictated by unknown, PT. claimant tolerated treatment well and reported some XX on mid XX area during MER. XXXX tolerated the treatment without any increased pain.

XXXX: Prescription for Physical/Occupational Therapy dictated by XXXX. DX: XX XX, XX and XX XX, chronic pain syndrome. Frequency: XX-XX x week for XX-XX weeks. Evaluate and treat: XX rehab with XX of choice.

XXXX: Operative Report dictated by XXXX. Pre-op Diagnosis: XX XX syndrome. Post-op syndrome: same as pre-op diagnosis. Operation: XX pain XX refill, analysis, and XX. Ultrasound guidance.

XXXX: Operative Report dictated by XXXX. Pre-op Diagnosis: XX XX syndrome. Post-op syndrome: same as pre-op diagnosis. Operation: XX pain XX refill, analysis, and reprogramming. Ultrasound guidance.

XXXX: Operative Report dictated by XXXX. Pre-op Diagnosis: XX pain XX. Post-op syndrome: same as pre-op diagnosis. Operation: XX pain pump refill, analysis, and reprogramming. Ultrasound guidance.

XXXX: Prescription for Physical/Occupational Therapy dictated by XXXX. DX: DDD XX, XX and XX XX, XX pain XX. Frequency: XX-XX x week for XX-XX weeks. Evaluate and treat: XX rehab with modalities of choice.

XXXX: Physical Therapy Evaluation dictated by unknown, PT. Assessment: XXXX with DX: XX XX, XX, post-XX syndrome. Deficits: pain, decreased ROM, decreased strength, decreased activity tolerance, impaired gait and tolerance.

XXXX: UR performed by XXXX. Reason for denial: Medical records reflect the claimant is a XXXX. The claimant is XX decompression at XX-XX and XX at XX-XX on XXXX and XX re-do XX XX at XX on XXXX. The claimant is diagnosed with XX XX, XX XX pain, post XX XX syndrome. Per PT evaluation dated XXXX,

the claimant reports XX pain at best XX/10, currently 7/10 and at worst 10/10. Activity when best: massage, heat, and deep water, and worst: twisting, bending, and squatting. The pain disturbs the claimant's XX. Most activities increase pain. XXXX reported treatment includes PT evaluation, conservative treatment (including previous physical/aquatic therapy), medications, s/p XX at XX and XX at XX on XXXX, MRIs, s/p re-do XX in XXXX, MBB, XX testing, cane, XX and XX XX XX implantation on XXXX. The claimant has previously attended aquatic PT. However, there is insufficient clinical information provided to support this request. Will need objective clinical information form the physician with detailed physical examination findings and claimant's objective response to prior aquatic physical therapy to guide and support ongoing aquatic PT. As presented, medical necessity is not established. Therefore, recommend non-certification for the request of additional physical/aquatic therapy XX
XXXX: UR performed by XXXX. Reason for denial: Per CA MTUS Guidelines, a trial of aquatic therapy is recommended for the treatment of subscribe or chronic XX XX pain in select patients. The claimant reported XX XX pain rated XX/10. XXXX has an XX pain XX. On PE the claimant XX with a XX in a forward flexion position. Deep XX XX were XX to light touch, pressure, and temperature to the XX XX XX. There was decreased ROM and strength. However, the claimant had previous aquatic physical therapy and there was not functional benefit documented. A peer to peer was not successful. As such, the request for physical/aquatic therapy XX a week times XX weeks total of XX sessions is non-certified.

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

Denial of XX sessions of Aquatics Therapy XX times a week for XX weeks is UPHELD/AGREED UPON since there is documentation of previous aquatics therapy with no objective improvement in XX Range of Motion or strength, and no functional improvement. After reviewing the medical records and documentation provided, there is no substantial evidence or documentation to warrant medical necessity for the requested aquatic therapy. The ODG Treatment Guidelines XX XX Chapter for Aquatics Therapy recommends as an optional form of exercise therapy, where available, as an alternative to land-based physical therapy. Therefore, the request for Physical/Aquatic Therapy XX, totaling XX sessions is denied.

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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)**