

Applied Independent Review

An Independent Review Organization

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A description of the qualifications for each physician or other health care provider who reviewed the decision:

Orthopedic Surgery
Orthopaedic Sports Medicine
Adult Spine Surgery

Description of the service or services in dispute:

Physical Therapy 2 X 4

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)

Patient Clinical History (Summary)

This case involves a XXXX with a history of an occupational claim from XXXX. The mechanism of injury is detailed as XXXX. The current diagnoses are documented as dysphagia, paraplegia, personality change due to conditions, and muscle spasm. Past treatment included multiple surgeries and 175 sessions of physical therapy since the date of injury. On XXXX, it was documented this patient had reported that XXXX was doing well with ongoing physical therapy. XXXX reported popping sound around XXXX peg site. Upon physical examination, it was noted XXXX had coarse breath sounds in the right lower lobe. XXXX was mobile in XXXX wheel chair and had full range of motion to the upper extremities.

Analysis and Explanation of the Decision include Clinical Basis, Findings and Conclusions used to support the decision.

According to the Official Disability Guidelines, physical medicine is recommended to restore function such as range of motion and motor strength. The guidelines indicate that no more than 48 sessions should be necessary with documentation noting objective functional improvement. The clinical documentation submitted for review indicated this patient had participated in 175 prior sessions of physical therapy since the date of injury. A rationale as to why the patient would be unable to participate solely in a home exercise program to restore and maintain function was not provided. The patient should be well-versed in a home exercise program given the number of past sessions. Consequently, the request is not supported. As such, the prior denial for the requested Physical Therapy 2 X 4 is upheld.

A description and the source of the screening criteria or other clinical basis used to make the decision:

- ☐ ACOEM-America College of Occupational and Environmental Medicine um knowledgebase AHRQ-
- ☐ Agency for Healthcare Research and Quality Guidelines
- ☐ DWC-Division of Workers Compensation Policies and 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 and Treatment Guidelines Pressley Reed, the Medical Disability
- ☐ Advisor
- ☐ Texas Guidelines for Chiropractic Quality Assurance and Practice Parameters Texas TACADA Guidelines
- ☐ TMF Screening Criteria Manual
- ☐ Peer Reviewed Nationally Accepted Médical **Literature** (Provide a description)
- ☐ Other evidence based, scientifically valid, outcome focused guidelines (Provide a description)