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DATE OF REVIEW: 8/30/18

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Physical therapy for XX XX and XX XX (XX times a week for XX weeks).

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

M.D., Board Certified in Physical Medicine & Rehabilitation/Sports Medicine.

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)

I have determined that the requested physical therapy for XX XX and XX XX (3 times a week for 4 weeks) is not medically necessary for the treatment of the patient's medical condition.

PATIENT CLINICAL HISTORY [SUMMARY]:

This case involves a XXXX with history of an XX claim from XXXX. The mechanism of injury was detailed as occurring when the patient was XXXX. The clinical note from XXXX notes that the patient reported constant pain prior to injection. The patient reports that XXXX was still having XX pain with some XX pain to the XX XX, XX XX of the XX and hand. The patient also noted that the XX pain that feels unrelated to the XX. The patient has some XX symptoms that XXXX feels XX from the XX to the XX XX on the

XX. The patient had a history of XX-XX XX pain. On examination, there was tenderness throughout the XX XX was moderate. Range of motion was XX XX. There was a XX XX XX. The patient had tenderness present to the XX arm XX XX as well as a XX XX. There was pain with range of motion. The patient had decreased XX strength at XX+/XX. The letter of medical necessity indicates that the patient was injured and has completed XX-XX visits of physical therapy without relief from a XX strain. XX XX therapy was not ordered until the XX visits of therapy. XX and XX pain are interrelated with XX XX movements referring pain to the XX XX XX with a XX XX XX to the XX XX XX. The patient also has marked pain to the XX with XX range of motion and muscle testing.

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

Per ODG Guidelines recommend XX visits over XX weeks for displacement of XX XX XX and XX visits over XX weeks for XX of the XX. The documentation indicates that the patient previously received XX-XX physical therapy visits. There was no clear evidence of the patient's objective functional improvement or decrease in pain with prior physical therapy visits. Also, the requested number of visits would exceed guideline recommendations. There was no indication of any exceptional factors to warrant the need to exceed guidelines recommendations. Therefore, the requested physical therapy for XX XX and XX XX, XX times a week for XX weeks is not medically necessary.

Therefore**,** I have determined the requested physical therapy for XX XX and XX XX (XX times a week for XX weeks) is not medically necessary for treatment of the patient's medical condition.

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**
  XX, Physical therapy; XX and XX XX, Physical therapy (PT)
- ☐ **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)**