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DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Physical Therapy XX X week for XX weeks

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]:

This case involves a now XXXX patient with an XX claim from XXXX. The mechanism of injury was detailed as a XXXX. The patient was seen for a physical therapy recertification on XXXX for a physical therapy evaluation of the XX XX and XX XX. The patient reported continued XX XX and XX XX pain, XXXX stated XXXX had improved function, range of motion and feeling as if the therapy did help improve XXXX function. XXXX reported XXXX had good and bad days, limitations in XX and functional activities but overall improvement. XXXX chief complaint was the XX XX. Objective data included mild XX of the XX XX was noted, XX in gait were noted, and the patient continued to have XX XX in the XX XX XX, XX XX region and the XX XX in the XX joint. The assessment was that the patient had been responding well to therapy, and exhibited improved functional mobility and overall activity tolerance based on performance during therapy sessions and objective measurements. The patient would continue to benefit from a progressive treatment approach that focused on reducing the risk of XX and improving overall functional XX. Therefore, the plan was to request additional physical therapy XX-XX times a week ×XX weeks. The treatment to be provided would be therapeutic exercises, therapeutic activity, gait training, neuromuscular rehabilitation, manual therapy and patient education. The patient was seen in clinic on XXXX with a chief complaint of

XX XX and XX XX tenderness. The physician reported that the patient had tried NSAIDs and pain medication with some improvement, and that the pain was aggravated by XX, XX, XX, XX and XX. Upon examination of the XX XX XX there was XX tenderness to XX present and pain with range of motion. Strength testing was limited secondary to pain, speeds and AC joint compression test were XX, XX XX XX, XX, and XX, and XX were equivocal, and the XX test was XX. The physician further noted the pain resolved after an injection. Examination of the XX XX revealed XX tenderness, no XX and no XX. The patient exhibited full range of motion and there was no weakness present. Examination of the XX XX revealed XX tenderness, no swelling, a well-healed incision, no XX and pain with range of motion. Strength testing revealed XX XX to pain. The patient walked with XX-XX gait. The diagnoses were a XX of XX XX, XX XX, XX XX strain, XX XX of the XX XX, acute XX XX XX to the XX XX, XX to the XX XX, and a XX XX. The treatment plan due to an MRI showing a XX in the XX XX, if symptoms persisted, the patient should consider surgical options in the future, recommendation currently was a XX for the XX XX, PT and medications. The same was true for the XX XX and if the symptoms persisted an arthroscopy and XX or repair of the XX would be recommended. The patient was to return to clinic in XX weeks.

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

According to the Official Disability Guidelines, physical therapy for a XX XX of the XX, medical treatment, is recommended as XX visits over XX weeks. Post-surgical treatment after a XX is XX visits over 12 weeks. In the clinical records submitted for review, the patient has completed XX sessions of physical therapy for the XX XX and XX. The therapist reported the patient had been responding well to therapy and exhibited improved functional mobility and overall activity tolerance based on performance during therapy sessions and objective measurements. The patient would continue to benefit from a progressive treatment approach that focused on reducing the risk of XX and improving overall functional mobility. The guidelines state that XX visits over XX weeks is the recommendation for medical treatment. The patient is in XX of the recommended number of visits at the current time.

Therefore, according to the guidelines, additional therapy visits is not medically necessary.

Therefore, the request for physical therapy XX x week for XX weeks 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

Official Disability Guidelines (ODG), Treatment Index, 16th Edition (web), 2018, XX and XX XX Chapter, Physical medicine treatment.