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DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
XX therapy XX sessions

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
Physical Medicine and Rehabilitation Physician

REVIEW OUTCOME:
Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

X 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. The exact mechanism of injury was not available.

On XXXX., evaluated the patient for XX-sided XX and XX XX pain. The patient reported chronic and ongoing XX pain affecting the XX XX XX and described as aching. The pain was constant and radiated around the XX XX to under the XX. XXXX was unable to work or carry out usual activities. The XX score was XX to XX/10, XX at best was XX/10 and XX at worst was XX/10. The patient reported full compliance with XX contract. XXXX also reported that lying down, massage, prescribed medications improved symptoms and activity, walking and exercises had no effect on symptoms. The vital signs indicated XX of XXXX. The patient was utilizing XXXX. Medical history was positive for XX, XX, XX gait, XX disease, XX XX and XX. Surgical history was positive for XX XX, XX and XX. Examination of the XX XX showed XX XX and XX range of motion (XX) with XX, extension and XX rotation. Examination of the XX XX showed XX XX and XX XX. XX. XX (XX) dated XXXX, was consistent with prescribed medications. The diagnoses were pain radiating to XX, XX XX pain, XX XX pain, long term use of XX XX and chronic pain syndrome. XXXX opined the patient had improved functionality, quality of life and XX control with current XX medication therapy for moderate to severe pain, unresponsive to non-XX medications alone. Without these medications, the patient would likely suffer XX of XX and XX pain. The patient was recommended continuing XX medication as part of multi-modal Pain Management treatment plan. Therapy goals for pain control were discussed. The patient was recommended considering

alternative therapy options such as aquatic therapy, yoga and massage. XXXX refilled XXXX.

On XXXX, noted the patient was doing fairly well. XXXX did employ a XX XX now. With XXXX XX, XXXX was safe and could walk up to XX miles. XXXX was XXXX. XXXX had been added to XX regimen which helped the XX XX XX and XX pain which XXXX started getting about XXXX months ago. The working diagnosis was XX. On exam, the XX XX was still a concern in that XXXX XX XX was XX. On exam, it was at XXXX. The gait was XX XX XX XX The patient remained XX in the XX with XXXX reflexes. XXXX motor power was XX/XX in XX. XXXX had a little bit of XX. XXXX has no XX tenderness. XXXX prescribed XX visits of XX therapy (PT) and refilled XXXX.

Per utilization review dated XXXX, the request for XX visits of XX for the XX XX was denied based on the following rationale *"Based on a review of the medical record submitted, the injury is* XX. *The claimant has had extensive XX therapy. It will not provide any significant long-term, curative or restorative benefit. At very best, the short-term palliations all that can be expected. At this time, the requested XX therapy for the XX XX XX visits, as an outpatient is recommended for noncertification as being not medically reasonable or necessary."*

On XXXX performed a peer review. XXXX noted the patient had attended XX sessions of XX from XXXX. From XXXX, the patient had attended XX sessions of XX. From XXXX, the patient attended XX sessions of XX. XXXX rendered following opinion: There was no evidence to support a diagnosis of XX, nor was there evidence that would support a causal relationship between the diagnosis and the original work injury. According to the last relevant office visit note, the patient was reporting chronic XX and XX pain and received maintenance treatment including prescription pain medication. The complaints/treatments appeared to be causally related to the original work injury. The patient had received extensive treatment for XXXX work injury. At that juncture, there was nothing else to offer the patient other than maintenance care with office visits quarterly for medication management under the direction of one physician. Maintenance of XX XX XX and provision of a XX XX XX would be appropriate. There was no indication for any further diagnostic testing or procedures, XX therapy, XX therapy, XX testing, pain programs, use of any additional XX such as a XX (XX) unit or further surgical interventions. According to the last office note, the patient was being prescribed XXXX. It appeared that XXXX was being prescribed for the compensable injury. The ongoing use of XXXX was supported by ODG. The effects of the work injury had not resolved. The patient appeared to be status post XX surgery for compensable injury with chronic residual pain complaints. These were unlikely to resolve in the foreseeable future.

Per correspondence dated XXXX was reported of the denial.

On XXXX, the patient appealed the denial. It was reported that XX was requested to try to maintain mobility and strength which was slowly XX. The XX would address other issues related to the new diagnosis of XX. XXXX had prescribed XXXX for XX caused by the XX. XXXX continued XX, stating that XXXX was a treatment for XX.

Per reconsideration review dated XXXX, appeal for XX sessions of XX for the XX XX was denied based on the following rationale *"This is a XX-XX chronic pain XX with XX XX XX use*

and multiple other XX. The last note from MD does not really show me any reason why XX would be needed. Possibly one or two sessions might be worth it to review XX, but since this is in Texas and there was no peer discussion, the request was unable to be modified. Therefore, the request for reconsideration for XX therapy of the low XX, XX visits, as an outpatient, is not medically necessary."

Per correspondence dated XXXX was notified about the denial.

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

I have reviewed the medical records and I cannot find evidence to support the need for XX visits of XX therapy sessions. The individual had extensive XX therapy in the past and this is a chronic condition with the injury occurring **XXXX** years ago. It is my opinion that additional will be of little or no benefit and the decision should be upheld.

X Not Medically Necessary

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

X ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES