Vanguard MedReview, Inc.
101 Ranch Hand Lane
Aledo, TX 76008
P 817-751-1632
F 817-632-2619

October 22, 2018 Amended October 29, 2018

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
XX Therapy XX X week for XX weeks

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
This case was reviewed by a licensed Chiropractor with over 20 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: MRI XX w/o contrast interpreted by XXXX. **Impression:** 1. XX of the XX XX XX. Suspected XX tear of the XX XX XX, not fully assessed on these images of the XX. XX of the XX is recommended to best assess the XX XX XX. 2. Remaining XX in the XX is XX. XX in the XX joint. Small high-grade partial or full XX XX at the XX XX of the XX at its insertion, not fully assessed on this exam. Mildly XX in the XX. 4. XX in the XX of the XX XX and XX.

XXXX: Office Report by XXXX **Subjective:** XX XX pain. Patient reported work injury XXXX. Reports occasional XX XX XX dn XX XX. No XX pain. **Physical Exam:** No deformities or misalignment of bones. There are XX, XX, XX, XX, or signs of XX. Upon palpation there is no XX, XX, XX or XX. The XX are normal and there is XX continuity of the anatomic structures. XX muscle more prominent XX. XX XX but XX at XX XX. ROM: flexion is XX°, extension is -XX°, XX is XX°. Strength testing of the XX flexors is graded at XX active movement against gravity and XX XX. Strength testing of the XX extenders is graded at XX/5. The deep XX XX of the in XX XX are symmetrical; they are graded at XX/4. Sensory testing XX is intact. **Assessment:** XX XX, XX XX, XX XX, XX. XX XX of XX XX, XX XX, init. **Plan:** XX of XX. Follow up as needed.

XXXX: MRI XX XX joint (XX) without contrast interpreted by XXXX. **Impression:** 1. Acute XX XX XX XX XX XX. The XX is XX at the insertion, XX XX to the XX junction. 2. Acute XX XX of the XX XX XX XX with XX surrounding the XX. There is some XX, but no organized XX. 3. Partial XX at the XX XX XX XX ligament near the XX of the XX XX. 4. XX XX injury. XX XX injury with a partial XX of the XX XX, at the XX. No high grade partial or full thickness XX. 5. Of note, there is an XX XX XX XX, not pathologically XX by size criteria.

XXXX: Office Report by XXXX Patient has XX XX XX pain since injury at work XXXX. XXXX reports XX and pain at XX XX XXXX. XXXX complains of pain with XX. MRI XXXX of XX reports complete XX of XX XX XX, partial XX XX XX muscle, XX XX XX XX ligament, XX and XX muscle injury. Discussed this would

best be treated with surgery.

XXXX: Operative Report by XXXX XX XX XX repair with XX XX XX, XX XX.

XXXX: Office Report by XXXX XX benign. No evidence of XX. Placed in XX XX XX Still elevate and minimize activity. Filled XX off work. Remove XX at next visit. XX.

XXXX: Office Report by XXXX ROM: XX°, XXX°, XX°. Removed XX and XX. Instructed home motion exercises. No lifting.

XXXX: Office Report by XXXX ROM: XX°, XX, XX XX. Muscle XX XX of the XX XX XX of the XX XX and XX is graded at XX/5. Start therapy. No lifting yet. XX duty.

XXXX: Office Report by XXXX Improving. ROM: XX XX XX°, XX°. No evidence of XX. Doing home motion exercises and therapy. Wrote to start light strengthening. Light duty.

XXXX: XX by XXXX,. **Assessment:** XXXX shows significantly improved functional ability in today's evaluation. XXXX has yet to return to normal XX. XXXX was XX XX during the evaluation and gave a genuine effort. 1. Patient is at XX for lifting. 2. Patient is at a XX repetitive activities. Recommendation: 1. Progress to strength phase. 2. RTW with restrictions.

XXXX: Office Report by XXXX Improving. ROM: XX XX is XX. Doing light strengthening in therapy. Had FCE done last week. Advance strengthening. Increased light duty.

XXXX: Office Report by XXXX Doing well at light duty. Awaiting approval for further therapy. XXXX needs further therapy for strengthening. XXXX job XX. XXXX XX repair XX with XX not usual direct repair. Light duty pending more PT.

XXXX: UR performed by XXXX, DC. **Rationale for Denial:** Recommend denial and non-certification of the services requested. The ODG would support up to XX sessions of post-operative PT over XX week period for the XX injury. XX sessions have been completed at this time. FCE XXXX demonstrates the claimant to be functioning in the heavy to very heavy PDL for repetitive activities. Despite this, the patient is under a XX pound lifting restriction at work because the treating doctor states that the patient is not able to do multiple repetitions and the XX just measured XX repetition. XXXX further explains that the patient needs to move into a strengthening phase now with XXXX therapy. It appears that the patient may have already reached the appropriate PDL as the treating confirms XXXX job description requires a heavy PDL (XX). The maximum ODG recommendations are not to be considered an entitlement. There is no objective evidence that this claimant would require anything further in the way of supervised care for this injury.

XXXX: UR performed by XXXX. **Rationale for Denial:** No further PT is medically necessary. The patient reports occasional XX with XX XX. This is typical with post-surgical status, and especially considering XXXX full ROM and muscle strength, is no cause for further care. Although the maximum amount of visits that could be approved using ODG may be up to XX visits over XX weeks, this maximum recommendation is not an entitlement. There is no evidence this patient requires more supervised care regarding this injury.

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

The medical documentation that has been reviewed reports that XXXX. XX of the XX XX was taken on XXXX underwent XX XX surgery performed by XXXX to repair the XX XX XX. XXXX attended physical therapy starting on XXXX. On XXXX, the documentation shows that XXXX has not returned to normal ADLs but XXXX is lifting at Heavy to very Heavy PDL. XXXX is at constant PDL for repetitive activities. ON

XXXX, the report written by XXXX. shows that XXXX has completed XX v post-XX visits and XXXX is functioning at XXXX required work PDL. Therefore, since the muscle strength has been returned to XX, and the ODG recommends XX visits of post-XX visits, XXXX has successfully returned to XXXX job PDL and XXXX should be instructed on an active self-directed home exercise and stretching routine. The ODG recommends the amount of visits for a diagnosis but the amount of treatments can vary from each patient. Therefore, physical XX x week for XX weeks is not medically necessary, and I am recommending upholding this denial of additional PT visits.

Per ODG:
XX

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)**