MEDRx

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DATE OF REVIEW: October 13, 2018

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE
XX

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

The reviewer is a Medical Doctor who is board certified in Orthopedic Surgery.

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)

The reviewer agrees with the previous adverse determination regarding the medical necessity of:
XX

PATIENT CLINICAL HISTORY [SUMMARY]:

This patient is a XXXX who sustained an industrial injury on XXXX. Injury occurred when a XXXX. The XXXX XX elbow x-ray impression documented a suggestion of a joint effusion XX pad, which might indicate a XX XX fracture. The XXXX XX XX x-ray impression documented XX abnormality of the XX XX. Findings documented the vertebral bodies were normal in height, disc spaces were normal, and alignment was normal. Records indicated that the patient attended at least XX sessions of physical therapy from XXXX.

The XXXX physical therapy initial evaluation form documented a chief complaint of intense grade XX/XX XX XX pain radiating down the XX leg with intermittent numbness and tingling and spasms. XXXX also reported full XX elbow range of motion but pain with full extension

over the XX elbow. XX elbow pain was grade XX/XX. The XX XX Index score was 86. XX exam documented mild restriction in flexibility, 3+/5 hip strength XX, positive XX straight leg raise, and pain with XX, XX, XX greater than XX. Active XX range of motion was documented as extension 0, flexion 25%, XX/XX rotation 50%, and XX/XX side bending 50%. XX elbow exam documented pain over the radial XX with palpation. The treatment plan recommended the patient attend rehabilitative therapy 3 visits a week for an expected duration of 4 weeks.

The XXXX physical therapy re-evaluation form documented completion of XX prior visits. The treating diagnosis was documented as XX XX strain and XX radius fracture. XXXX chief complaint was intense XX XX pain radiating down the XX leg with intermittent numbness and tingling and spasms. XXXX also reported full XX elbow range of motion but pain with full extension over the XX elbow. Pain was reported grade XX/XX, with no changes in XXXX XX XX or XX elbow pain. XXXX had an MRI today and was to follow-up with XXXX physician next week. Further imaging of the elbow was pending. XXXX was not currently working. XX XX Index score was documented as 88 on XXXX and 82 on XXXX. XX exam documented mild restriction in flexibility, 3+/5 hip strength XX, positive XX straight leg raise, and pain with XX, XX greater than XX. Active XX range of motion was documented as extension 30%, flexion 75%, XX/XX rotation 50%, and XX/XX side bending 50%. XX elbow exam documented mild restriction in flexibility, pain over the radial XX, and -18 to 128 degrees. It was noted that the patient continued to demonstrate decreased positional tolerances, pain with transitional movements, decreased XX active range of motion, decreased XX elbow active range of motion, and decreased strength. It was noted that XXXX would continue to benefit from skilled therapy in order to address identified impairments, return to prior level of function, return to work, and improve quality of life. The treatment plan recommended that the patient attend rehabilitative therapy 2 visits a week for an expected duration of 4 weeks. It was noted that the patient lacked an appropriate home exercise program.

The XXXX Physical/Occupational Therapy Preauthorization Request Form requested physical therapy 3 times per week for 4 weeks to include CPT codes XX.

The XXXX utilization review determination indicated that the request for physical therapy 3 times per week for 4 weeks for the XX elbow and XX XX was non-certified as not medically necessary. The rationale indicated that the patient had completed a total of XX sessions and the primary treating physician indicated during the peer-to-peer discussion that XXXX did not need any additional therapy.

The XXXX utilization review determination letter indicated that the request for physical therapy 3 times per week for 4 weeks for the XX elbow and XX XX was non-certified as not medically necessary. The rationale indicated that the patient had exceeded the recommended total number of physical therapy visits based on treatment guidelines and was expected to be able to perform a home exercise program independently at this point.

The XXXX utilization review determination letter indicated that the request for physical therapy 3 times per week for 4 weeks for the XX elbow and XX XX was non-certified as not medically necessary. The rationale documented a peer-to-peer discussion with the treating physician who indicated that XXXX last saw the patient in XXXX and the patient was found to be at maximum

medical improvement and discharged. The treating physician indicated that XXXX wrote a prescription for physical therapy in XXXX and had not ordered additional physical therapy, although XXXX staff might have stamped this physical therapy request.

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

1) XX elbow & XX XX, per XXXX order (XX) is not medically necessary. The denial is upheld.
2) The prospective request for manual therapy technique 3 times weekly, per XXXX order (XX: XX) is not medically necessary. The denial is upheld.
3) The prospective request for therapeutic procedure(s) XX elbow & XX XX, per XXXX order (XX: XX) is not medically necessary. The denial is upheld.
4) The prospective request for therapeutic activities, XX elbow & XX XX, per XXXX order (XX: XX) is not medically necessary. The denial is upheld.
5) The prospective request for PT re-evaluation, XX elbow & XX XX, per XXXX order (XX: 1) is not medically necessary. The denial is upheld.
6) The prospective request for PT evaluation, XX elbow & XX XX, per XXXX order (XX: 1) is not medically necessary. The denial is upheld.
7) The prospective request for PT 3 times weekly XX elbow & XX XX, per XXXX order (XX: XX) is not medically necessary. The denial is upheld.

The Official XX Guidelines - XX XX recommend physical therapy for a diagnosis of XX sprain/strain for XX visits over XX weeks, and for XX XX-XX visits over XX weeks. Guidelines allow for fading of treatment frequency (from up to 3 or more visits per week to 1 or less), plus active self-directed home PT.

The Official XX Guidelines - Elbow recommend physical therapy for elbow sprain/strain 9 visits over XX weeks and for medical treatment of upper limb fracture XX visits over XX weeks. Guidelines generally recommended up to 3 visits contingent on documentation of objective improvement, i.e. VAS improvement of greater than 5, and further trial visits with fading frequency up to 6 contingent on further objectification of long-term resolution of symptoms, plus active self-directed home PT.

This patient presents with complaints of grade XX/XX XX XX pain radiating down the XX lower extremity with numbness and tingling and grade XX/XX XX XX elbow pain with full extension. XXXX is not currently working. XXXX has completed XX sessions of physical therapy from XXXX. There has been no change in the XX since XXXX. The XX functional inventory score is virtually unchanged over the course of physical therapy care, from XXXX. The physical therapist reports the patient demonstrates decreased positional tolerances, pain with transitional movements, decreased XX active range of motion, decreased XX elbow active range of motion, and decreased strength. The treatment plan recommended XX additional visits. Under consideration is a request for XX additional visits. This request for additional physical therapy exceeds guideline recommendations. There is no recent primary treating physician report to support the medical necessity of this request in the submitted medical records. There is no rationale presented to support the discrepancy between the physical therapist's treatment plan and the request for treatment. In the absence of pain reduction and significant functional

improvement, continuation of physical therapy services is not supported by guidelines. There is no compelling rationale presented or extenuating circumstances noted to support the medical necessity of additional physical therapy services as an exception to guidelines. Therefore, the above outlined requests for physical therapy services are not medically necessary.

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 XX XX 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 XX GUIDELINES & TREATMENT GUIDELINES**

  ODG Treatment
  Integrated Treatment/XX Duration Guidelines
  Elbow
  Physical therapy
  Updated 6/25/18

  ODG Treatment
  Integrated Treatment/XX Duration Guidelines
  XX XX
  Physical therapy (PT)
  Updated 7/6/18
- ☐ **PRESSLEY REED, THE MEDICAL XX 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)**