

# CASEREVIEW

8017 Sitka Street  
Fort Worth, TX 76137  
Phone: 817-226-6328  
Fax: 817-612-6558

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## DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Physical Therapy XX

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

This physician has over 20 years of experience in Physical Medicine and Rehabilitation.

## 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]:

The claimant is a XXXX who was injured on XXXX. XXXX underwent XX knee XX reconstruction with XX, along with XX and XX XX performed by XXXX. The claimant received XX visits of post-op physical therapy. More therapy was recommended and as of the PT note dated XXXX, the claimant had attended XX sessions of PT.

On XXXX, the claimant presented to XXXX for a physical therapy re-evaluation. XXXX reported general XX knee XX, XX, and XX, with XX motion and sense of strength. XXXX presented in a brace locked in extension and using a XX for XX in XX, and XX for XX distances. It was recommended that XXXX received physical therapy XX-XX times a week for XX-XX weeks.

On XXXX performed a UR. Rationale for Denial: There was a previous determination dated XXXX, whereby the previous reviewer non-certified the request for physical therapy XX-XX

times a week for XX-XX weeks for the XX knee. The reviewer noted that as this is a Texas case that could not be modified, the requested physical therapy XX-XX times XX-XX significantly would exceed guideline recommendations of up to XX visits post XX XX XX reconstruction when combined with the XX sessions. Therefore, the requested physical therapy XX-XX times a week times XX-XX weeks XX XX was not medically necessary and was non-certified.

On XXXX, the claimant presented to XXXX. for post-op evaluation. XXXX was improving as expected. XXXX described the pain as XX. XXXX continued to progress with PT/HEP. XXXX was ambulating in XX-XX XX unlocked and was ready to transition to XX XX per PT. On examination of the XX knee, the incision was well healed with no signs of XX. No signs of XX. No tenderness noted. XX swelling. ROM progressing as expected. Strength progressing as expected. Plan: NSAIDS and ICE, seated duty work restrictions, transition to XX knee XX, physical therapy.

On XXXX added an addendum to XXXX original UR Denial: A successful peer to peer conversation occurred with XXXX. We discussed clinical details, associated guidelines and appeal potential if deemed at all applicable. The provider reiterated the clinical findings and agreed with this reviewers draft opinion. Therefore, the requested appeal physical therapy 2-3 times a week for 4-6 weeks left knee is not medically necessary and is non-certified.

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

Determination: Denial of additional Post-operative Physical Therapy visits XX-XX times a week for XX-XX weeks is UPHELD/AGREED UPON since the request exceeds ODG recommendations of number of post ACL reconstruction PT visits and time frame (XX over XX weeks), and clinically Physical Therapy notes confirm XX post op visits from XXXX with progression but plateau in XX knee Range of motion XX2 extension/XX XX) and plateau in XX knee strength (XX/5 extension and flexion).

There is also question as to compliance with home exercise program and consideration of progression to more comprehensive, functional rehabilitation programs now XX months post injury and XX months post-op. Therefore, the request for Physical Therapy XX-XX-XX XX Knee is not found to be medically necessary.

**PER ODG: XX**

**ODG Criteria**

**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)**