

---

Notice of Independent Review Decision

**DATE OF REVIEW: 6/18/07****IRO CASE #:****DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

Occupational therapy.

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

This case was reviewed by a board certified physical medicine and rehabilitation specialist on the external review panel who is familiar with the condition and treatment options at issue in this appeal.

**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)

<i>Primary Dx Code</i>	<i>HCPCS /NDC</i>	<i>Mod</i>	<i>Units</i>	<i>Type Review</i>	<i>DOS</i>	<i>Amt Billed</i>	<i>Date of Injury</i>	<i>Claim #</i>	<i>Uphold / Overturned</i>
				Prospective					Uphold

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

1. Request for Independent Review by an Independent Review Organization forms – 5/31/07.
2. Determination Notices – 4/27/07, 5/16/07.
3. Records and Correspondence from Group and Center– 12/15/06-6/1/07.
4. Records and Correspondence from Hospital – 12/14/06.
5. Records and Correspondence from Peer Review – 1/17/05, 3/9/07.

## **PATIENT CLINICAL HISTORY:**

This case concerns an adult male who sustained a work related injury. Records indicate that he sustained injury to his left upper arm from an 8-10 foot fall. Records also noted that at the time he underwent surgery to repair a fractured arm. Diagnoses have included left arm fracture of the humerus and radius, radial nerve palsy, left rotator cuff tear, and adhesive capsulitis. Evaluation and treatment for this injury has included surgery, medications, and occupational therapy.

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

The patient incurred a work related injury from a fall. A list of injuries and surgeries included left humerus fracture with radial nerve injury and open reduction, internal fixation (ORIF) and ORIF of left distal radius fracture. After therapy, the patient returned to light duty work but continued to have left shoulder pain. He was diagnosed with frozen shoulder in April 2006. In August 2006, a diagnosis of severe carpal tunnel syndrome (CTS) was made and in November 2006 an MRI of the left shoulder revealed chronic tear of the infra and supraspinatus tendons with retraction. The patient underwent left shoulder arthroscopy surgery with biceps tenotomy, rotator cuff repair and sub acromial decompression. At his initial occupational therapy evaluation on 12/26/06 he was noted to have decreased passive range of motion in the left shoulder and decreased muscle strength. He received occupational therapy 3 times per week consisting of ultrasound and electrical stimulation modalities, joint mobilization and active and passive exercises. There was no significant improvement noted in passive range of motion in the left shoulder on re-evaluation on 2/2/07. He continued with occupational therapy through 3/7/07. He had improved range of motion, improved strength and increased functional use of the left shoulder. Left shoulder flexion was noted to be 0-50 degrees, extension was 0-33 degrees, and abduction was 0-40 degrees. It was unclear if this was active or passive motion. His range of motion was still moderately limited and he continued with occupational therapy. He continued to have increasing active range of motion in the left shoulder and increased passive range of motion. He still experienced pain in abduction greater than 100 degrees. He was seen by an orthopedic doctor on 5/4/07 and noted to have excellent passive range of motion of the shoulder both passively and actively. He was also noted to have some weakness to flexion and abduction with the same findings on 6/1/07.

It appears that the patient has received occupational therapy services post operatively beyond the 24 visits per the Official Disability Guidelines (ODG). Physician visits on 5/4/07, 5/18/07 and 6/11/07 record good passive and active range of motion with the left shoulder, but some weakness in flexion and abduction. Further supervised skilled therapy is not medically necessary as the patient has good active and passive range of motion and need to continue to work on strengthening exercises. After receiving multiple sessions of occupational therapy, the patient should be able to perform strengthening exercises for the left shoulder on his own with a home exercise program.

Therefore, the requested continued occupational therapy services are not medically necessary for treatment of the member's condition.

**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)