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**Date notice sent to all parties:** 04/16/18
**IRO CASE #:** XXXXXX

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**
Occupational therapy 2 times a week for 4 weeks for the right arm/shoulder

**A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:**
Board Certified in Orthopedic Surgery
Diplomate of the American Board of Orthopedic Surgery
Fellow of the American Academy of Orthopedic Surgeons
Fellow of the American Association of Orthopedic Surgeons

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

**X** Upheld (Agree)

☐ Overturned (Disagree)

☐ Partially Overturned (Agree in part/Disagree in part)

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

Occupational therapy 2 times a week for 4 weeks for the right arm/shoulder – Upheld

**PATIENT CLINICAL HISTORY [SUMMARY]:**
XX examined the patient on XXXX and it was noted XX was XX. XX had significant injuries with a temporary loss of consciousness. XX had right shoulder numbness, tingling, weakness, and pain. A right shoulder C5-C6 avulsion injury was felt to be XX primary working diagnosis. An MRI and EMG/NCV study were recommended. The patient was then evaluated in occupational therapy on XXXX and it was recommended XX. The patient then attended occupational therapy from XXXX through XXXX for XX visits. An EMG/NCV study on XXXX revealed moderate axonal injury to the right cervical nerve root consistent with the right C5-C6 and C6-C7 levels. There was moderate chronic right median motor and

sensory neuropathy in the wrist and mild acute left median sensory neuropathy at the wrist. Severe atrophy of the right supraspinatus, infraspinatus, deltoid, and biceps muscles was noted on the EMG portion. There was felt to be strong evidence of severe right axillary and suprascapular motor nerve neuropathy or/with upper trunk of right brachial plexopathy. A right shoulder MRI on XXXX revealed non-specific, diffuse intramuscular edema involving both the supraspinatus and infraspinatus muscles. There was also a high grade partial/full thickness posterior component of the supraspinatus tendon. XX performed right radial nerve exploration, neurolysis, transfer of triceps branch to axillary nerves, axillary nerve neuroplasty, right spinal accessory nerve exploration, neurolysis, transfer to suprascapular nerve, suprascapular nerve neuroplasty, and right brachial plexus decompression, exploration, and neurolysis on XXXX. On XXXX, the patient was XX post surgery and occupational therapy was recommended at that time. On XXXX, the patient was evaluated in therapy, which was recommended 3 times a week for 4 weeks. The patient then attended therapy from XXXX through XXXX for a total of XX visits and was then reevaluated on XXXX. XX range of motion was improved by 20% and continued therapy was recommended at that time. The patient then attended therapy on XXXX and XXXX and returned to XX on XXXX. XX had improved range of motion, but still had restricted overhead use. Continued therapy was recommended at that time. The patient continued in occupational therapy from XXXX through XXXX for an additional XX visits. XX was then reevaluated on XXXX. XX still had significant limitation in right grip strength when compared to the left. Continued therapy was recommended, which the patient attended from XXXX through XXXX for XX more visits. XX was then reevaluated on XXXX. XX still had popping of the right shoulder with elevation, but XX pain was improved. XX right grip strength had improved by 60 pounds. An additional 8 sessions were recommended at that time. On XXXX, the patient informed XX that on Monday when XX stood up, XX felt XX shoulder coming of out the socket and when XX went to therapy, the put it back in and taped XX. XX had been wearing a sling ever since, which was continued. Another MRI on XXXX showed a focal bony contusion along the superior anterior aspect of the humeral head, which was associated with a mild subdeltoid bursitis. On XXXX, XX recommended therapy focused on exercises in the frontal plane. On XXXX, XX provided a letter of adverse determination for the requested occupational therapy. XX and XX provided a letter of medical necessity on XXXX. On XXXX, XX provided another adverse determination for the requested XX sessions of occupational therapy.

**ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:**
The patient is a XX who reportedly was XX right shoulder, causing XX in XXXX. XX sustained multiple injuries to include loss of consciousness, pulmonary contusion, right rib fractures, L1 and L3 fractures, right leg laceration, and second and third degree burns. The patient subsequently underwent nerve reconstructive procedures by XX on XXXX to include a right radial nerve triceps branch to the axillary nerve, right spinal accessory nerve to the supraspinatus nerve, and right brachial plexus decompression. XX subsequently has undergone a total of XX

formal occupational therapy sessions based on the documentation provided for review. Review of the medical record, however, demonstrates inconsistent attendance with only XX sessions the entire month XXXX, for example. In addition, large gaps as demonstrated by no therapy from XXXX through XXXX are also noted. The patient has made some improvement, but has not returned to work in any capacity since the injury. XX is now over XX status post injury and over XX status post nerve reconstructive procedures. The request was non-certified by XX, upon initial review on XXXX. XX attempted a peer-to-peer without success. XX, upheld the non-certification on reconsideration/appeal on XXXX. XX attempted a peer-to-peer, but was able to speak to a therapist. Both reviewers cited the evidence based Official Disability Guidelines (ODG) as the basis of their opinions.

The evidence based ODG recommends for brachial plexus lesions, if medical treatment is instituted, 14 visits over XX weeks. Postsurgical treatment recommendations include 20 visits over 10 weeks. The patient is over XX status post surgical procedure and has completed a total of XX sessions. The ODG physical therapy guidelines allow for fading of treatment frequency (from up to three visits per week to one or less) plus an active, self-directed home therapy program. The patient would be expected at this point to be on an active, self-directed home therapy program. The recommendation does not meet the criteria as outlined above. In addition, the ODG recommends the use of active treatment modalities instead of passive treatment is associated with substantively better clinical outcomes. The most commonly used active treatment modality is therapeutic exercises, but other active therapies may be recommended, as well including neuromuscular reeducation, manual therapy, and therapeutic activity/exercises. Physical modalities such as massage, diathermy, cutaneous laser treatment, ultrasonography, transcutaneous electrostimulation units, and biofeedback are not supported by high-quality medical studies, but they may be useful in the initial conservative treatment of acute shoulder symptoms depending upon the experience of local physical therapy providers. Therefore, the requested occupational therapy 2 times a week for XX weeks for the right arm/shoulder is not medically necessary, reasonably related, or supported by the evidence based ODG and the previous adverse determinations should be upheld at this time.

**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**

X MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

☐ MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

☐ MILLIMAN CARE GUIDELINES

X 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)