PO Box 519
Schertz, TX 78154

ACCREDITED
Independent Review Organization Accreditation: Comprehensive Review
Expires: 06/01/2027

**Notice of Workers' Compensation Independent Review Decision**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**
X

**1) Is the requested 1 hour stretch and massage therapy for left upper extremity x 24 session (2 times a week for 12 weeks) medically necessary and appropriate?**

**Answer:** No, the requested X is not medically necessary and not appropriate.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW:**
X

**PATIENT CLINICAL HISTORY [SUMMARY]:** In this case, the claimant was involved in a work-related injury with a motor vehicle accident while on active duty as a police officer X. X was diagnosed with hemiplegia and hemiparesis following cerebral infarction affecting left nondominant side, and muscle spasm. According to the physical therapy notes on X, the claimant has completed X sessions. Spastic alopecia of the left side, muscle spasms in left upper and lower extremities, neuropathy, weakness of left upper extremity, paralysis and pain in left upper extremity, and cervical region, listed diagnoses. The patient is unable to perform functional internal rotation reach. X reported tenderness in the left, left lateralis major and upper trapezius. X walks without an assistive device. The provider requested and stressed the importance of continuing the X for X. The patient has had over X sessions and over X sessions, according to evidence gathered during a successful peer-to-peer discussion. The X was denied by the health plan.

In the Letter of Medical Necessity dated X, the provider stated that the patient had a significant improvement with range and spasticity after botulinum injections; however, X continues to have subjective feelings of tightness on left side compared tohis right side. The patient will benefit from regular exercise, stretching, and strengthening to decrease spasms, increase ROM, improve function and participation in therapy and independence and ease of caregiving.

**ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:**
According to Official Disability Guidelines (ODG) Massage for Shoulder Conditions is generally recommended as an option. While very little research has been conducted into the effectiveness of massage for shoulder pain, recent research is painting a more favorable picture.

According to Official Disability Guidelines (ODG) Massage Therapy is conditionally recommended as an option; maybe a first-line or second line option. Massage is the manipulation of soft tissue and muscles to promote healing. Many studies of massage therapy use a frequency of 1-2 times a week for a duration of 4-8 weeks, but there is significant variability in type of massage, frequency, and duration of treatment.

In this case, the medical records do not support this request because the X exceeded the recommended number of X visits in accordance with Official Disability Guidelines. Despite receiving a significant amount of care, the patient's symptoms persisted. On the basis of the records analyzed and/or the absence of them, as well as the cited recommendations, X is advised to be denied.

As such, the denial of X is upheld as not medically necessary and not appropriate.

**SOURCE OF REVIEW CRITERIA:**

☐ ACOEM – American College of Occupational & Environmental Medicine UM Knowledgebase
☐ AHRQ – 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 Judgment, Clinical Experience, and Expertise in Accordance with Accepted Medical Standards
☐ Mercy Center Consensus Conference Guidelines
☐ Milliman Care Guidelines
☒ ODG- Official Disability Guidelines & Treatment Guidelines
☐ Presley Reed, the Medical Disability Advisor
☐ Texas Guidelines for Chiropractic Quality Assurance & Practice Parameters
☐ TMF Screening Criteria Manual
☐ Peer Reviewed Nationally Accepted Medical Literature (Provide a Description)
☐ Other Evidence Based, Scientifically Valid, Outcome Focused Guidelines (Provide a Description)

**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

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

X