

<b>Case Number:</b>	CM14-0106053		
<b>Date Assigned:</b>	07/30/2014	<b>Date of Injury:</b>	08/25/2004
<b>Decision Date:</b>	08/29/2014	<b>UR Denial Date:</b>	06/24/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/09/2014

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer is Board Certified in Physical Medicine and Rehabilitation, has a subspecialty in Pain Medicine and is licensed to practice in Texas and Oklahoma. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The injured worker is a 60-year-old female who reported an injury 08/25/2004. The mechanism of injury was not provided within the medical records. The clinical note dated 07/02/2014 indicated the injured worker reported neck pain, shoulder pain, and arm pain with occasional numbness in her arm. The injured worker reported she still had very little function in her shoulder. On physical examination, the injured worker's hand, wrist and elbow were swollen. The injured worker's range of motion revealed 30 degrees of elevation, forward flexion, and abduction. The injured worker was able to passively and externally rotate 30 degrees with external rotational lag back to neutral. The injured worker's forward flexion was 90 degrees, external rotation was 90 degrees, internal rotation was 70 degrees, and the injured worker extended 30 degrees. The injured worker had a positive belly press and weakness of the supraspinatus and external rotators. The injured worker's prior treatments included physical therapy/occupational therapy, and medication management. The injured worker's medication regimen was not available for review. The provider submitted a request for occupational therapy to include massage therapy 3 times 6 for the right shoulder. A request for authorization was not submitted for review to include the date the treatment was requested.

### IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

**Occupational Therapy - to include massage therapy 3x6 for the right shoulder:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 24.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines PHYSICAL MEDICINE Page(s): 98.

**Decision rationale:** The request for Occupational Therapy - to include massage therapy 3x6 for the right shoulder is non-certified. The California MTUS state that active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. Active therapy requires an internal effort by the individual to complete a specific exercise or task. The guidelines note injured workers are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. There is lack of documentation indicating the injured worker's prior course of therapy as well as the efficacy of the therapy. The provider did not indicate a rationale for the request. Therefore, the request is non-certified.