

<b>Case Number:</b>	CM14-0049164		
<b>Date Assigned:</b>	06/25/2014	<b>Date of Injury:</b>	01/01/2005
<b>Decision Date:</b>	07/25/2014	<b>UR Denial Date:</b>	03/18/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/26/2014

### 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 61-year-old female who reported an injury on 01/01/2005. The mechanism of injury was not provided within the medical records. The clinical note dated 03/05/2014 indicated diagnoses of shoulder pain and extremity pain and entrapment neuropathy of upper limb. The injured worker reported right shoulder pain rated 6/10. She reported her activity level had increased and reported she took her medication as prescribed. The injured worker reported her medications were working well. The injured worker reported she was informed that she had been authorized for occupational therapy; however, it was authorized for an area that was too far to attend. The injured worker was interested in going to occupational therapy with the therapist who had previously worked with her to her benefit. On physical examination of the right shoulder, the injured worker's movements were restricted with flexion limited to 105 degrees, extension limited to 20 degrees, abduction limited to 75 degrees, and internal rotation behind the body limited to 10 degrees. The injured worker's Hawkins test was positive and Neer's test was positive. The injured worker's empty can test was positive and the injured worker's Jobe's test was positive as well as the Popeye's sign. There was tenderness to palpation at the biceps groove and supraspinatus. The injured worker's motor testing was limited and sensory exam was decreased. The injured worker's prior treatments included diagnostic imaging, surgeries and medication management. The injured worker's medication regimen included Flexeril, Norco, Resteril, and Fioricet. The provider submitted a request for occupational therapy for the right shoulder with [REDACTED], OTR. A request for authorization dated 03/11/2014 was submitted for occupational therapy for outside occupational therapist [REDACTED], OTR; however, a rationale was not provided for review.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Occupation Therapy for the right shoulder with [REDACTED], O.T.R., Qty: 12.00:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines occupational therapy.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99.

**Decision rationale:** The request for Occupation Therapy for the right shoulder with [REDACTED], O.T.R., Qty: 12.00 are not medically necessary. The Chronic Pain Medical Treatment Guidelines state 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 injured worker reported her activity level has increased and reported her medications were working well. In addition, the injured worker has undergone prior occupational therapy; however, the number of sessions and efficacy was not provided to support additional sessions. The completed occupational therapy should have been adequate to improve functionality and transition the injured worker to a home exercise program where the injured worker may continue with exercises such as strengthening, stretching, and range of motion. Moreover, the request does not specify a timeframe for the therapy. Therefore, the request for occupational therapy for the right shoulder quantity 12 are not medically necessary.