

Case Number:	CM13-0056481		
Date Assigned:	02/26/2014	Date of Injury:	04/14/2009
Decision Date:	05/09/2014	UR Denial Date:	11/13/2013
Priority:	Standard	Application Received:	11/22/2013

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 Family Practice and is licensed to practice in Texas. 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 54-year-old male who reported an injury on 04/14/2009. The mechanism of injury was noted to be trying to hold onto a cart to prevent it from falling, causing the injured worker to fall. Physical examination revealed range of motion of the lumbosacral spine to be 10 degrees flexion, 15 degrees extension, 15 degrees right lateral flexion, and 15 degrees left lateral flexion. The injured worker was diagnosed with pain in shoulder joint region. Past medical treatment included physical therapy. Diagnostic studies include an MRI of the left shoulder in 2010. On 08/01/2013, a request for a shoulder rehab kit had been made. A rationale for the requested treatment was not provided.

IMR ISSUES, DECISIONS AND RATIONALES

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

RETROSPECTIVE REQUEST FOR A SHOULDER REHAB KIT FOR THE LEFT SHOULDER, PURCHASED ON 9/3/2013: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain , Exercise,Physical Medicine Page(s): 46-47,98-99.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Exercise Page(s): 46-47.

Decision rationale: The Expert Reviewer's decision rationale: According to the California MTUS Guidelines, exercise is recommended. There is strong evidence that exercise programs, including aerobic conditioning and strengthening, is superior to treatment programs that do not include exercise. There is no sufficient evidence to support the recommendation of any particular exercise regimen over any other exercise regimen. The documentation submitted for review fails to provide evidence of subjective or objective functional deficits for the left shoulder. The documentation also failed to provide a rationale for the requested treatment. As the guidelines state there is no sufficient evidence to support the recommendation of any particular exercise over any other exercise regimen, and the documentation failed to provide rationale for the requested shoulder rehab kit, the request is not supported. Given the above, the request for retrospective request for a shoulder rehab kit for the left shoulder, purchased on 09/03/2013, it non-certified.