

<b>Case Number:</b>	CM14-0114808		
<b>Date Assigned:</b>	08/04/2014	<b>Date of Injury:</b>	02/28/2013
<b>Decision Date:</b>	01/23/2015	<b>UR Denial Date:</b>	06/23/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/21/2014

### 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 Rehab, has a subspecialty in Interventional spine and is licensed to practice in California. 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 patient is a 47-year old female with an injury date of 02/28/13. As per progress report dated 05/17/14, the patient complains of chronic pain in right shoulder that increases when she lifts the arm above the shoulder level. The intermittent, severe and burning pain is rated at 9/10. The pain radiates to neck and also produces tingling and popping sensations. The patient has difficulties with activities of daily living. Physical examination reveals tenderness over the anterior aspect of the shoulder. Range of motion is painful on forward flexion, external rotation, and abduction. The patient has also been diagnosed with insomnia, as per progress report dated 05/30/14. The patient has received chiropractic treatment and shockwave therapy, as per progress report dated 05/17/14. Current medications include cyclobenzaprine, ibuprofen and creams, as per the same report. The patient also received Kenalog and Lidocaine injection in the subacromial space on 05/17/14. Additionally, the patient has received at least 10 sessions of physical therapy, as per therapy report dated 02/11/14. The patient is currently totally temporarily disabled, as per progress report dated 05/17/14. EMG/NCV, 12/17/13, as per progress report dated 05/17/14: Abnormal nerve conduction study suggestive of carpal tunnel syndrome MRI of the Right Shoulder, 11/15/13, as per progress report dated 05/17/14:- Supraspinatus tendinitis- Infrapinatus tendinitis- Subchondral cyst formation within the humeral headMRI of the Cervical Spine, 03/05/14:- Straightening of cervical lordosis- Central focal disc protrusion at C4-5, C5-6 and C6-7 that abuts the thecal sac. The neuroforaminal are patent. Sudoscan, 02/20/14: Small fiber neuropathy in hands. Diagnosis, 05/17/14: Right shoulder subacromial tendinitis. The treater is requesting for 1- Exercise Rehab Kit. The utilization review determination being challenged is dated 06/23/14. The rationale was the records submitted for review failed to include documentation that the patient had been instructed regarding the exercises to be

performed as well as the proper exercise technique. Treatment reports were provided from 01/07/14 - 06/06/14.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**Exercise Rehab Kit:** Overturned

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints. Decision based on Non-MTUS Citation Exercise

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder (acute & chronic) and topic Home exercise kits Knee & leg chapter, DME

**Decision rationale:** The patient presents with chronic pain in right shoulder, rated at 9/10, that increases when she lifts the arm above the shoulder level, as per progress report dated 05/17/14. The request is for 1- Exercise Rehab Kit. The ODG Guidelines, chapter 'Shoulder (acute & chronic)' and topic 'Home exercise kits', state that the kits are recommended where home exercises and active self-directed home physical therapy is recommended. Regarding DME, ODG guidelines, Chapter Knee & Leg and Title DME, states that The term DME is defined as equipment which: (1) Can withstand repeated use, i.e., could normally be rented, and used by successive patients; (2) Is primarily and customarily used to serve a medical purpose; (3) Generally is not useful to a person in the absence of illness or injury; & (4) Is appropriate for use in a patient's home. (CMS, 2005)" DME is "Recommended generally if there is a medical need and if the device or system meets Medicare's definition of durable medical equipment (DME) below. In this case, the patient suffers from severe shoulder pain. She has received some physical therapy, chiropractic treatment, and shockwave therapy. Transitioning to a home exercise regimen with the help of exercise rehab kit appears reasonable at this time. The ODG guidelines support it for shoulder problems. The request is medically necessary.