

Case Number:	CM15-0000500		
Date Assigned:	01/12/2015	Date of Injury:	12/05/2013
Decision Date:	03/17/2015	UR Denial Date:	12/11/2014
Priority:	Standard	Application Received:	01/02/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation

CLINICAL CASE SUMMARY

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

This 43 year old male suffered an industrial injury on 12/5/13 with subsequent pain to bilateral hands and wrists, right elbow, bilateral shoulders, thoracic and lumbar spine and bilateral feet. The injured worker complained of ongoing bilateral upper extremity, back and neck pain. EMG/NCV of bilateral upper extremities (10/24/14) showed ulnar neuropathies at both elbows consistent with mild to moderate cubital tunnel syndrome. In a PR-2 dated 11/4/14, the injured worker complained of bilateral shoulder pain. Physical exam was remarkable for full shoulder elevation bilaterally with slight pain with rotator cuff loading bilaterally. The physician noted that despite complaint of shoulder pain, the injured worker's physical findings were slight, suggestive of mild rotator cuff disease. In a PR-2 dated 11/17/14, the injured worker reported continued bilateral shoulder pain that occurred with movement. The injured worker reported increased difficulty with lifting, pushing and pulling secondary to pain. Physical exam was remarkable for left shoulder with tenderness to palpation and limited range of motion. Current diagnoses included rotator cuff syndrome of shoulder, shoulder sprain/strain, rotator cuff capsule sprain and degeneration of thoracic or lumbar intervertebral disc. Work status was temporary total disability. The treatment plan included a resistance chair exercise rehabilitation system freedom flex shoulder stretcher, Percocet 10/325 once daily as needed for pain, ice and heat to bilateral shoulders and continuing home exercise program. On December 11, 2014, Utilization Review noncertified a request for a resistance chair exercise rehabilitation system freedom flex shoulder stretcher. No guidelines were cited by the Claims Administrator. As a result of the UR denial, an IMR was filed with the Division of Workers Comp.

IMR ISSUES, DECISIONS AND RATIONALES

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

Resistance Chair Exercise Rehab System Freedom Flex Shoulder Stretcher: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines ESI Page(s): 46-47. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) - Knee & Leg Chapter, Exercise Equipment and Durable Medical Equipment Shoulder Chapter, Exercise

Decision rationale: The patient is status post right rotator cuff repair 03/25/14 and presents with shoulder pain. The request is for RESISTANCE CHAIR EXERCISE REHAB STRETCHER SYSTEM FREEDOM FLEX SHOULDER. Patient's medications include Percocet and Paxil, per treater report dated 11/19/14. The patient is on home exercise program. The patient is temporarily totally disabled. MTUS, Exercise, pages 46, 47 state that it is recommended; however, there is not sufficient evidence to support any particular exercise regimen over any other. ODG, Shoulder Chapter, Exercise states therapeutic exercise, including strengthening, is recommended and should be started as soon as it can be done without aggravating symptoms. ODG does not discuss DME/Exercise equipment for the shoulder. ODG guidelines Knee & Leg Chapter, Exercise Equipment and Durable Medical Equipment, state is recommended generally if there is a medical need and if it fits the following Medicare definition: Can withstand repeated use; Primarily serves a medical purpose, Generally is not useful to a person in the absence of illness or injury; Is appropriate for use in the patient's home." Per progress report dated 11/19/14, treater is requesting Resistance Chair "for home use to progress patient's home exercise program with exercise emphasis to address continued weakness." There is a strong support from all the guidelines for exercises that can be performed by the patient. ODG guidelines do provide some support for exercise kits for various conditions. The current request appears reasonable given the patient's chronic shoulder condition that require stretching and strengthening. The request IS medically necessary.