

Case Number:	CM15-0104652		
Date Assigned:	06/09/2015	Date of Injury:	12/22/2003
Decision Date:	07/09/2015	UR Denial Date:	05/15/2015
Priority:	Standard	Application Received:	06/01/2015

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: Maryland

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Neuromuscular Medicine

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 63 year old female, who sustained an industrial injury on 12/22/03. She has reported initial complaints of right knee injury. The diagnoses have included left rotator cuff tear, left shoulder pain, right knee meniscus tear and right knee pain. Treatment to date has included medications, activity modifications, off work, diagnostics, acupuncture, surgery and physical therapy. Currently, as per the physician progress note dated 4/7/15, the injured worker complains of achy, sharp left shoulder pain that radiates to the left arm associated with repetitive movement and relief from medications and acupuncture. The objective findings reveal that the range of motion to the left shoulder is decreased and painful. The supraspinatus press causes pain. The right knee ranges of motion are painful, flexion is 125 degrees/140 degrees, and McMurray's sign is positive on the right. The diagnostic testing that was performed included Left shoulder Magnetic Resonance Imaging (MRI) dated 1/15/15 reveals osteoarthritis, bicipital tenosynovitis, and tendinosis. The current medications included Naproxen, Pantoprazole, Cyclobenzaprine and topical creams. There was previous therapy sessions noted in the records. The physician requested treatments included Shoulder home exercise rehab kit for purchase and Knee home exercise rehab kit for purchase due to constant pain and weakness.

IMR ISSUES, DECISIONS AND RATIONALES

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

Shoulder home exercise rehab kit for purchase: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Exercise Page(s): 46.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical medicine Page(s): 98-99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder-home exercise kits.

Decision rationale: Shoulder home exercise rehab kit for purchase is not medically necessary per the MTUS Guidelines and the ODG. The MTUS states that home exercise can include exercise with or without mechanical assistance or resistance and functional activities with assistive devices. The ODG states that shoulder exercise kits are recommended as an option where home exercise programs are recommended. The request states that the shoulder home exercise rehab kit is for reasons of constant pain and weakness. The 5/8/15 progress note does not contain evidence of any weakness. Furthermore, the documentation is not clear on what is contained within this kit and why the patient requires specialized equipment. The request for a shoulder home exercise rehab kit for purchase is not medically necessary.

Knee home exercise rehab kit for purchase: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Exercise Page(s): 46.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical medicine Page(s): 98-99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee/leg- home exercise kits.

Decision rationale: Knee home exercise rehab kit for purchase is not medically necessary per the MTUS Guidelines and the ODG. The MTUS states that home exercise can include exercise with or without mechanical assistance or resistance and functional activities with assistive devices. The ODG states that knee exercise kits are recommended as an option where home exercise programs are recommended. The request states that the knee home exercise rehab kit is for reasons of constant pain and weakness. The 5/8/15 progress note does not contain evidence of any subjective right knee complaints and the objective physical exam does not reveal evidence of weakness. Furthermore, the documentation is not clear on what is contained within this kit and why the patient requires specialized equipment. The request for a knee home exercise rehab kit for purchase is not medically necessary.