

<b>Case Number:</b>	CM15-0042468		
<b>Date Assigned:</b>	03/12/2015	<b>Date of Injury:</b>	07/24/2009
<b>Decision Date:</b>	05/22/2015	<b>UR Denial Date:</b>	02/03/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/06/2015

### 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: New York, West Virginia, Pennsylvania  
 Certification(s)/Specialty: Emergency 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 55 year old female who sustained an industrial injury on 07/24/2009. The injured worker was diagnosed with left shoulder impingement with partial rotator cuff tear, labral anterior tear and acromioclavicular synovitis/arthritis. Treatment to date includes diagnostic testing, trigger point injections, intra-articular injections, surgery, physical therapy, home exercise program and medications. The injured worker is status post arthroscopic subacromial decompression, acromioplasty, coracoacromial ligament resection, Mumford procedure and debridement of the labral and rotator cuff of the left shoulder on Aug 15, 2014. According to the treating physician's latest progress report on November 17, 2014, the injured worker was 2 months post-op and enrolled in physical therapy with some decreased range of motion but making excellent progress. Forward flexion was 136 degrees, abduction to 96 degrees and strength 3/5 on the left upper extremity. Current medications were not documented. Treatment plan was for additional physical therapy at that time. The current review consists of the request for a left shoulder home physical therapy kit purchase.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Left Shoulder, Home Physical Therapy exercise kit, purchase:** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder, Home exercise kits.

**Decision rationale:** Guidelines recommend home exercise kits where home exercise programs and self directed home physical therapy are recommended. In this case, the exact content of the exercise kit was not described. The physical examination from physical therapy did not support the need for more than a Thera-Band for strengthening exercises. The request for the exercise kit for the left shoulder is not medically necessary and appropriate.