

<b>Case Number:</b>	CM15-0025479		
<b>Date Assigned:</b>	02/18/2015	<b>Date of Injury:</b>	05/05/2011
<b>Decision Date:</b>	05/11/2015	<b>UR Denial Date:</b>	01/13/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/10/2015

### 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: 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 40-year-old female, with a reported date of injury of 05/05/2011. The diagnoses include right shoulder impingement, right acromioclavicular cartilage disorder, right subacromial/subdeltoid bursitis, partial tear of the right rotator cuff, and calcific tendinitis of the right infraspinatus tendon of the right shoulder. Treatments to date have included an MRI of the right shoulder and right shoulder injection. The comprehensive orthopedic evaluation report dated 12/24/2014 indicates that the injured worker presented for a subacromial corticosteroid injection into the right shoulder. She complained of pain in the right shoulder, rated 8 out of 10, with numbness and tingling radiating down into the hand. The physical examination of the right shoulder showed extremely limited range of motion. The treating physician requested post-operative home exercise kit for the shoulder.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**DME: Post-Op: Home Exercise Kit (Shoulder): Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

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

**Decision rationale:** The requested DME: Post-Op: Home Exercise Kit (Shoulder), is not medically necessary. CA MTUS 2009 Chronic Pain Treatment, Exercise, Pages 46-47 strongly recommend exercise as an integral part of a rehabilitation program; however, the guidelines do not specifically address exercise supplies. ODG Guidelines note that no evidence supports stretching as effective treatment for acute low back problems, but it may be used as part of an exercise program, and it may aid in prevention. The injured worker has right shoulder pain. The treating physician has documented limited right shoulder range of motion. The treating physician has not documented detailed description of the constituent parts of the kit. The criteria noted above not having been met, DME: Post-Op: Home Exercise Kit (Shoulder) is not medically necessary.