

<b>Case Number:</b>	CM15-0069205		
<b>Date Assigned:</b>	04/16/2015	<b>Date of Injury:</b>	06/23/2014
<b>Decision Date:</b>	05/15/2015	<b>UR Denial Date:</b>	03/20/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/13/2015

### 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, Pain Management

### 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 34 year old male, who sustained an industrial injury on 06/23/2014. He reported pain to his left shoulder, left forearm, left wrist, and left hand/fingers. The injured worker is currently diagnosed as having left shoulder impingement, left elbow lateral epicondylitis, and status post partial amputation of left long finger distal joint. Treatment and diagnostics to date has included physical and manipulating therapy, injections, shockwave treatment, and medications. In a progress note dated 01/27/2015, the injured worker presented with complaints of shoulder pain and left elbow pain as well as left long finger symptoms. The treating physician reported requesting authorization for a hand/wrist home exercise rehabilitation kit.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Home exercise rehab kit:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 MTUS (Effective July 18, 2009) Page(s): 46-47 of 127.

**Decision rationale:** Regarding the request for Home exercise rehab kit, Occupational Medicine Practice Guidelines support the use of aerobic activity to avoid deconditioning. ODG states that exercise is recommended. They go on to state that there is no sufficient evidence to support the recommendation of any particular exercise regimen over any other exercise regimen. Guidelines do not support the need for additional exercise equipment, unless there is documentation of failure of an independent exercise program without equipment, despite physician oversight and modification. Within the documentation available for review, there is no indication that the patient has failed an independent program of home exercise without equipment. Additionally, there is no statement indicating how the requested exercise equipment will improve the patient's ability to perform a home exercise program, or that the patient has been instructed in the appropriate use of such equipment to decrease the chance of further injury. In the absence of such documentation, the currently requested Home exercise rehab kit is not medically necessary.