

<b>Case Number:</b>	CM15-0007217		
<b>Date Assigned:</b>	01/26/2015	<b>Date of Injury:</b>	01/12/2013
<b>Decision Date:</b>	03/24/2015	<b>UR Denial Date:</b>	12/04/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/13/2015

### 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, Arizona

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:

The injured worker is a 36 year old female, who sustained an industrial injury to right upper extremity and back on 1/12/13. She has reported back, right hand and shoulder discomfort and numbness. The diagnoses have included right shoulder impingement and right carpal tunnel. Treatment to date has included medications and diagnostics. Currently, the IW complains of clicking and popping in the right shoulder and difficulty with any lifting or over shoulder work. Magnetic Resonance Imaging (MRI) of the right shoulder dated 9/10/13 revealed subchondrial cyst in the posterolateral aspect of the humeral head. Physical exam revealed clicking with circumduction of the shoulder and evidence of subluxation related to the clicking in the area of the biceps tendon. There is positive impingement sign with some mild crepitus. Carpel compression testing is positive. On 12/4/14 Utilization Review non-certified a request for Right shoulder arthroscopy with debridement and acromioplasty with bicepstenotomy and modified a request for Postoperative OT twice a week for four weeks to 4 sessions at 2 times a week for 1 week and then 1 times a week for 2 weeks, noting there was no documentation of biceps tendon sheath injection no documentation of amount of physical therapy rendered and if the IW is performing a Home Exercise Program (HEP). There is lack of exhausting conservative measures. The (MTUS) Medical Treatment Utilization Schedule and Official Disability Guidelines (ODG) were cited.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Right shoulder arthroscopy with debridement and acromioplasty with bicepstenotomy:**  
Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Indications for Surgery - Acromioplasty

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints  
Page(s): 209-210..

**Decision rationale:** According to the California ACOEM Guidelines, surgical interventions are indicated for those who have emergence of a red flag, imaging studies showing a positive deficit, and for those who have failed conservative treatment. Based on the clinical documentation submitted for review, the injured worker was noted to be symptomatic regarding the right shoulder. However, there is a lack of documentation showing that she has tried and failed all recommended conservative measures to support the request for a surgical intervention. Therefore, the request is not supported. As such, the request is not medically necessary.

**Post-Operative Occupational Therapy (8-sessions, 2 times a week for 4 weeks):** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Postsurgical Treatment Guidelines Page(s):  
27.

**Decision rationale:** As the requested surgical intervention is not supported by the documentation, the requested ancillary service is also not supported.