

<b>Case Number:</b>	CM14-0121836		
<b>Date Assigned:</b>	09/16/2014	<b>Date of Injury:</b>	05/23/2012
<b>Decision Date:</b>	10/28/2014	<b>UR Denial Date:</b>	07/11/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/01/2014

### 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. The expert reviewer is Board Certified in Orthopedic Surgery and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### 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 48 year old female who had a work-related injury on 05/23/12. The mechanism of injury was not described. The most recent medical note submitted for review, dated 01/16/14, noted that the injured worker continues to have increasing pain and frustration with regard to her right shoulder. She is progressively becoming more depressed by her lack of authorization. On physical examination of the right shoulder, the injured worker has abduction to 80 degrees, forward flexion 90 degrees, and external rotation 70 degrees. Impingement signs are markedly positive on Hawkin's and Neer testing with crepitation. Diagnosis is chronic right shoulder impingement with diminishing range of motion. Status post right wrist triangular fibrocartilage complex debridement. There have been no MRI studies, x-rays, or physical therapy notes submitted for review. Requests for right shoulder arthroscopy subacromial decompression and post-op physical therapy 3 x 4 right shoulder was denied in the prior utilization review process on 07/11/14.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Right shoulder arthroscopy Subacromial Decompression:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 211.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation (ODG) Shoulder chapter, Surgery for impingement syndrome

**Decision rationale:** The request for right shoulder arthroscopy with subacromial decompression is not medically necessary. Clinical data submitted for review does not support the request. There is no documentation of failed conservative measures including physical therapy, nonsteroidal anti-inflammatory drugs, injection therapy, etc. There has been no MRI of the shoulder or x-rays of the shoulder submitted for review as well. Based on the evidenced based guideline recommendations,, the requested procedure is not supported by the provided clinical data and medical necessity has not been established.

**Post - op Physical Therapy 3 X 4 right shoulder:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Postsurgical Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines C.C.R. 9792.20 - 9792.26; MTUS (Effective July 18, 2009 Page(s): 27.

**Decision rationale:** The request for post-op physical therapy 3 X 4 for the right shoulder is predicated on the initial surgical request. As this has not been found to be medically necessary, the subsequent request is not necessary.