

<b>Case Number:</b>	CM15-0068080		
<b>Date Assigned:</b>	04/22/2015	<b>Date of Injury:</b>	08/22/2013
<b>Decision Date:</b>	07/21/2015	<b>UR Denial Date:</b>	03/13/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/10/2015

### 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: New York  
Certification(s)/Specialty: Neurological Surgery

### 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 25-year-old female, who sustained an industrial injury on August 22, 2013, incurring injuries to her back and shoulder. She was diagnosed with a cervical spine strain, thoracic spine sprain, lumbosacral sprain and a right shoulder strain. Treatment included anti-inflammatory drugs and activity restrictions. Currently, the injured worker complained of neck pain with headaches and right arm numbness, low back pain, and right shoulder pain. The treatment plan that was requested for authorization included an arthroscopic acromioplasty and distal clavicle resection of the right shoulder, pre-operative medical clearance with an Internist, post-operative physical therapy to the right shoulder, a (CPM) continuous passive motion machine rental, hot and cold therapy unit rental and an arm sling.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Arthroscopic Acromioplasty and Distal Clavicle Resection, Right Shoulder:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines, Shoulder, Partial Claviclectomy (Mumford Procedure).

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints  
Page(s): 209, 202, and 205.

**Decision rationale:** The California MTUS guidelines recommend surgical consideration when there is clear clinical and imaging evidence of a lesion that is shown to benefit both in short and long term from surgical repair. The patient's clinical exam does not report frequent nocturnal pain or pain in reaching overhead. The diagnosis of an impingement syndrome was raised in January 1015 when the initial injury was in August 2013. The progress notes carried the diagnosis of shoulder contusion. The guidelines recommend a home exercise program. Details of such a program are not found in the documentation. The requested treatment: Arthroscopic Acromioplasty and Distal Clavicle Resection, Right Shoulder is not medically necessary and appropriate.

**Pre-Operative Medical Clearance with an Internist:** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**Post-Operative Physical Therapy, 3 times a week for 4 weeks, Right Shoulder:** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**Associated surgical service: CPM Machine for 28 days rental:** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**Associated surgical service: Hot/Cold Therapy Unit for 28 days rental:** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**Associated surgical service: Arm Sling:** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.