

<b>Case Number:</b>	CM15-0129035		
<b>Date Assigned:</b>	07/15/2015	<b>Date of Injury:</b>	09/25/2014
<b>Decision Date:</b>	08/13/2015	<b>UR Denial Date:</b>	06/22/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/02/2015

### 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, Indiana, Oregon  
 Certification(s)/Specialty: Orthopedic 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 31 year old female with an industrial injury dated 09/25/2014. Her diagnoses included right shoulder rotator cuff tear, left shoulder sprain and strain and right hand/wrist sprain and strain. The mechanism of injury is documented as slipping and falling on a wet floor. She fell on the right side of her body experiencing neck pain, bilateral shoulders, right arm, hand and mid back. Prior treatment included chiropractic treatment, diagnostics, TENS unit and medications. She presented on 06/11/2015 with complaints of right upper extremity radicular pain rated as 7/10. Right shoulder exam showed poor mobility and pain with overhead reach. The provider documented MRI was positive for rotator cuff tear. Chiropractic treatment was only mildly helpful and the provider recommended physical therapy and acupuncture to increase mobility/strength and decrease pain. The treatment request is for arthroscopic rotator cuff repair, acromioplasty and distal clavicle resection of the right shoulder, 12 post-op physical therapy sessions, associated surgical service: 1 CPM machine, associated surgical service: ultra-sling and associated surgical service: 1 cold therapy unit.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**1 arthroscopic rotator cuff repair, acromioplasty and distal clavicle resection of the right shoulder:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 210. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Rotator cuff repair, Acromioplasty, Partial calviculectomy.

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

**Decision rationale:** Based upon the CA MTUS Shoulder, Pages 209-210 recommendations are made for surgical consultation when there is red flag conditions, activity limitations for more than 4 months and existence of a surgical lesion. The Official Disability Guidelines Shoulder section, Partial Claviculectomy, states surgery is indicated for post traumatic AC joint osteoarthritis and failure of 6 weeks of conservative care. In addition there should be pain over the AC joint objectively and/or improvement with anesthetic injection. Imaging should also demonstrate post traumatic or severe joint disease of the AC joint. In this case the MRI shows only mild degenerative changes in the AC joint. Based on this the request is not medically necessary.

**Associated surgical service: 1 cold therapy unit:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 203. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder-Acute & Chronic-Continuous flow cryotherapy.

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

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

**Associated surgical service: 1 CPM machine:** 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), Shoulder -Acute & Chronic-Continuous passive motion (CPM).

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

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

**Associated surgical service: 1 Ultrasling:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 205.

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

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

**12 post-op physical therapy sessions:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 205.

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

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