

Case Number:	CM14-0151601		
Date Assigned:	09/19/2014	Date of Injury:	06/22/2014
Decision Date:	10/23/2014	UR Denial Date:	09/11/2014
Priority:	Standard	Application Received:	09/17/2014

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 Orthopaedic Surgery, and is licensed to practice in Montana. 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 male firefighter who sustained injuries to the right shoulder and knee in a fall on a wet slope while fighting a wildfire. Plain films on the following day of the right shoulder demonstrated a Hill-Sachs defect of the right humeral head and significant right acromioclavicular joint (AC) arthrosis. He has continued limited right shoulder range of motion (ROM) throughout range of motion (ROM), particularly in abduction and overhead positions. Medications, activity modification and physical therapy (PT) have not been helpful. A magnetic resonance (MR) arthrogram of the right shoulder on 8/6/14 demonstrated a small full thickness tear of the supraspinatus, acromioclavicular joint (AC) arthrosis with impingement and a normal labrum and glenohumeral joint. When evaluated by an orthopaedic surgeon on 8/ 28/14, the injured worker had 80 degrees of active abduction, negative apprehension sign and 4/5 rotator cuff strength. There was tenderness over the subacromial space and the bicipital groove. Having failed conservative treatment, a right shoulder arthroscopy with acromioplasty and distal clavicle excision with possible rotator cuff and labral repair has been requested. This was denied on the basis that the injured worker had not yet completed 3 months of conservative treatment. That denial is being appealed.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right Shoulder Arthroscopy with possible rotator cuff Repair QTY: 1.00: Overturned

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 210. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder, Surgery for rotator cuff repair

Decision rationale: The Medical Treatment Utilization Schedule (MTUS) guidelines do not address shoulder arthroscopic procedures for rotator cuff repair. The Official Disability Guidelines (ODG) state (the American College of Occupational and Environmental Medicine [ACOEM] recommendations are similar): Criteria for rotator cuff repair with diagnosis of full thickness rotator cuff tear and cervical pathology and frozen shoulder syndrome have been ruled out: 1. Subjective Clinical Findings: Shoulder pain and inability to elevate the arm; tenderness over the greater tuberosity is common in acute cases. [this is met. The injured worker has pain and weakness in all planes of motion of the rotator cuff and tenderness in the subacromial space.] 2. Objective Clinical Findings: Injured worker may have weakness with abduction testing. [This is met; this is documented and may also demonstrate atrophy of shoulder musculature. Usually has full passive range of motion. 3. Imaging Clinical Findings: Conventional x-rays, anterior posterior views, and true lateral or axillary views and gadolinium magnetic resonance imaging, ultrasound, or arthrogram shows positive evidence of deficit in rotator cuff. [This is met and documented as a full thickness tear of the supraspinous area on the magnetic resonance imaging (MRI) with Hill Sachs lesion on plain films. The previous denial was predicated on lack of documentation of failure of 3 months of conservative treatment. However, conservative treatment is not mandated for active workers with full thickness rotator cuff tears. This injured worker is a wild land firefighter with a full thickness rotator cuff tear. As the Official Disability Guidelines (ODG) and the American College of Occupational and Environmental Medicine (ACOEM) guideline criteria are met as above the requested right shoulder arthroscopy with possible rotator cuff repair is medically necessary.

Possible Cuff and Labral Repair: Overturned

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 210. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder, Surgery for SLAP lesions

Decision rationale: The Medical Treatment Utilization Schedule (MTUS) guidelines do not address labral tears. Labral tears are part of a continuum of anterior shoulder dislocation and rotator cuff tears. The injured worker has a Hill Sachs lesion on plain films and the magnetic resonance imaging (MRI) is consistent with right shoulder subluxation/dislocation. The American College of Occupational and Environmental Medicine (ACOEM) guidelines default to the algorithm for rotator cuff tears and the injured worker has already met these criteria for right shoulder arthroscopy and rotator cuff tear. The labrum would be examined at the time of surgery and appropriate interventions would be undertaken based on the rotator cuff pathology noted at

that time. The Official Disability Guidelines (ODG) recommend repair of type II and IV labral tears and debridement of type I and II lesions. Type II lesions are common in injured workers over the age of forty with a supraspinatus tear. The injured worker has a supraspinatus tear and is > 40 years old. If a labral tear is present at the time of the right shoulder arthroscopy, it is recommended that the treatment be based on the pathology noted at the time of surgery with it recommended that debridement or repair is medically necessary.

Partial Acromioplasty: Overturned

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

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

Decision rationale: The Medical Treatment Utilization Schedule (MTUS) guidelines do not address acromioplasty. The Official Disability Guidelines (ODG) and the American College of Occupational and Environmental Medicine (ACOEM) guidelines are similar for acromioplasty with impingement syndrome: Criteria for anterior acromioplasty with diagnosis of acromial impingement syndrome (80% of these injured workers will get better without surgery.)1. Conservative Care: Recommend 3 to 6 months: Three months is adequate if treatment has been continuous, six months if treatment has been intermittent. Treatment must be directed toward gaining full range of motion (ROM), which requires both stretching and strengthening to balance the musculature. [This is met. The injured worker has failed 3 months of conservative treatment including physical therapy (PT), medications, and activity modification.]2. Subjective Clinical Findings: Pain with active arc motion 90 to 130 degrees. and pain at night. [This is met. There is documented painful arc and constant pain.]3. Objective Clinical Findings: Weak or absent abduction; may also demonstrate atrophy and tenderness over rotator cuff or anterior acromial area and positive impingement sign and temporary relief of pain with anesthetic injection (diagnostic injection test). [This is met. All of these signs and symptoms are documented, as the injured worker has a full thickness rotator cuff tear, a subacromial injection is not recommended.]4. Imaging Clinical Findings: Conventional x-rays, anterior posterior views, and true lateral or axillary view and gadolinium magnetic resonance imaging (MRI), ultrasound, or arthrogram shows positive evidence of impingement. [This is met. This is documented on plain films and magnetic resonance imaging (MRI) with right acromioclavicular joint (AC) arthrosis present.]As the American College of Occupational and Environmental Medicine (ACOEM) and the Official Disability Guidelines (ODG) are met as noted above, the requested partial acromioplasty is medically necessary.

Distal Clavicle Resection: Overturned

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 210-214. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder, Surgery for impingement syndrome

Decision rationale: The Medical Treatment Utilization Schedule (MTUS) does not address distal claviclectomy. The Official Disability Guidelines (ODG) Indications for Surgery (the American College of Occupational and Environmental Medicine [ACOEM] recommendations are similar) address partial claviclectomy. The criteria for partial claviclectomy (includes Mumford procedure) with diagnosis of post-traumatic arthritis of acromioclavicular (AC) joint:1. Conservative Care: At least 6 weeks of care directed toward symptom relief prior to surgery. (Surgery is not indicated before 6 weeks.) [This is met. The injured worker has failed 3 months of conservative treatment.]2. Subjective Clinical Findings: Pain at acromioclavicular (AC) joint; aggravation of pain with shoulder motion or carrying weight or previous grade I or II AC separation. [This is met and documented.]3. Objective Clinical Findings: Tenderness over the acromioclavicular (AC) joint (most symptomatic injured workers with partial acromioclavicular (AC) joint separation have a positive bone scan) and/or pain relief obtained with an injection of anesthetic for diagnostic therapeutic trial. [This is met. The injured worker has pain over the acromioclavicular joint and subacromial space with positive impingement signs.]4. Imaging Clinical Findings: Conventional films show either: Post-traumatic changes of acromioclavicular (AC) joint or severe degenerative joint disease (DJD) of acromioclavicular joint or complete or incomplete separation of acromioclavicular joint and bone scan is positive for acromioclavicular joint separation. [This is met. The magnetic resonance imaging (MRI) and plain films are consistent with acromioclavicular joint arthrosis and impingement syndrome.]As the Official Disability Guidelines (ODG) and the American College of Occupational and Environmental Medicine (ACOEM) criteria are met as noted above, the requested distal claviclectomy is medically necessary.