

Case Number:	CM15-0060325		
Date Assigned:	04/06/2015	Date of Injury:	01/28/2008
Decision Date:	05/12/2015	UR Denial Date:	03/17/2015
Priority:	Standard	Application Received:	03/30/2015

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: Illinois, California, Texas
 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 43-year-old male who sustained an industrial injury on 1/28/08. Injury occurred when he fell down stairs at work and injured his right shoulder, right ankle and neck. He underwent an arthroscopic subacromial decompression and excision of os acromiale in 2008. The 1/16/15 right shoulder MRI impression documented a prominent 13 mm partial thickness bursal sided tear in the supraspinatus. The acromion demonstrated type I configuration. The acromioclavicular (AC) joint demonstrated moderate arthrosis with large bone spurs impressing upon the supraspinatus. The 3/10/15 treating physician report cited persistent right shoulder pain. The injured worker was unable to sleep well and had pain with overhead activities, lifting, reaching, and active range of motion. He had multiple right shoulder corticosteroid injections with temporary symptom relief, and physical therapy and home exercise with only minimal relief. He was not able to work. Physical exam documented tenderness over the rotator cuff and bicipital groove, snapping and popping with external rotation, pain with range of motion testing, mildly positive Yergason's test, and positive impingement sign. The rent test was irregular with snapping on examination. Range of motion was limited to 160 degrees forward flexion and 40 degrees external rotation. X-rays were taken and revealed a pre-acromion os acromiale, calcium deposits within the AC joint, and AC degenerative joint disease. The right shoulder MRI showed a 13 mm partial thickness supraspinatus tear with moderate AC joint arthrosis. There was a spur that appeared to stick down into the rotator cuff at the AC joint. The diagnosis was right AC degenerative joint disease, rotator cuff tear, biceps tendinitis, and pre-acromion os acromiale. Despite report of prior decompression and excision of os acromiale, there remained an os

acromiale and calcium deposits within the AC joint, along with new findings of a rotator cuff tear and biceps irregularity on examination. The injured worker had undergone comprehensive conservative treatment without sustained improvement. He continued to experience right shoulder pain that limited his daily life and precluded return to work. Authorization was requested for right shoulder arthroscopic rotator cuff repair, subacromial decompression, Mumford procedure, os acromiale excision and a possible biceps tenotomy. The 3/17/15 utilization review modified a request for arthroscopic rotator cuff repair, subacromial decompression, Mumford procedure, os acromial excision, and possible biceps tenotomy to arthroscopic rotator cuff repair, subacromial decompression, and modified Mumford procedure removing bone only from the underside of the joint in the same plane as the subacromial decompression. The request for os acromiale excision was non-certified based on absence of independent x-ray evidence, no evidence on MRI, and no symptoms attributable to the os. The request for possible biceps tenotomy was non-certified as there was no evidence of biceps pathology on imaging or specific biceps complaint.

IMR ISSUES, DECISIONS AND RATIONALES

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

Mumford Procedure: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines-Indications for Surgery.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-211. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder: Partial claviclectomy.

Decision rationale: The California MTUS ACOEM guidelines state that surgical consideration may be indicated for patients who have red flag conditions or activity limitations of more than 4 months, failure to increase range of motion and shoulder muscle strength even after exercise programs, and clear clinical and imaging evidence of a lesion that has been shown to benefit, in the short and long-term, from surgical repair. The Official Disability Guidelines provide criteria for partial claviclectomy that include 6 weeks of directed conservative treatment, subjective and objective clinical findings of acromioclavicular (AC) joint pain, and imaging findings of AC joint post-traumatic changes, severe degenerative joint disease, or AC joint separation. Guideline criteria have been met. This injured worker presents with signs/symptoms, clinical exam findings, and imaging evidence of AC joint arthrosis with impingement. Partial certification is noted for co-planning along same plane as the certified subacromial decompression. It is reasonable to allow the operating surgeon the discretion to perform the resection deemed appropriate at the time of arthroscopic evaluation. Therefore, this request is medically necessary.

Os acromial Excision: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): 210.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-211. Decision based on Non-MTUS Citation Ortiguera CJ, Buss DD, Surgical management of the symptomatic os acromiale. J Shoulder Elbow Surg. 2002 Sep-Oct; 11(5):521-8.

Decision rationale: The California MTUS ACOEM guidelines state that surgical consideration may be indicated for patients who have red flag conditions or activity limitations of more than 4 months, failure to increase range of motion and shoulder muscle strength even after exercise programs, and clear clinical and imaging evidence of a lesion that has been shown to benefit, in the short and long-term, from surgical repair. The California MTUS, Official Disability Guidelines, and National Guideline Clearinghouse do not address surgery for os acromiale. Current peer-reviewed literature suggests that initial treatment of symptomatic os acromiale includes physical therapy, non-steroidal anti-inflammatory drugs (NSAIDs), and subacromial cortisone injections. Surgical intervention is reserved for patients who do not respond to non-operative treatment. Guideline criteria have been met. This injured worker presents with continued right shoulder pain despite comprehensive conservative treatment. There is reported radiographic evidence of os acromiale. There is plausible evidence of os acromiale which can be symptomatic. Therefore, this request is medically necessary.

Biceps Tenotomy: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-211. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder: Surgery for ruptured biceps tendon (at the shoulder).

Decision rationale: The California MTUS ACOEM guidelines state that surgical consideration may be indicated for patients who have red flag conditions or activity limitations of more than 4 months, failure to increase range of motion and shoulder muscle strength even after exercise programs, and clear clinical and imaging evidence of a lesion that has been shown to benefit, in the short and long-term, from surgical repair. The Official Disability Guidelines support the use of biceps tenodesis or tenotomy for treatment of partial tears of the long head of the biceps tendon. Guideline criteria have been met for a possible biceps tenotomy. This injured worker presents with persistent right shoulder pain despite comprehensive conservative treatment. There is clinical exam evidence of biceps pathology. Occult biceps tendon tears, incomplete and MRI-negative, are often confirmed at the time of arthroscopic surgery. Therefore, this request is medically necessary.