



**MEDICAL EVALUATORS  
OF T E X A S ASO, L.L.C.**

1225 North Loop West • Suite 1055 • Houston, TX 77008  
800-845-8982 FAX: 713-583-5943

**Notice of Independent Review Decision**

**DATE OF REVIEW:** June 11, 2014

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

*Excision of Ectopic Bone of Right Shoulder with Neer Acromioplasty*

**A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION**

This case was reviewed by a physician who holds a board certification in Orthopedic Surgery and is currently licensed and practicing in the State of Texas.

**REVIEW OUTCOME**

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

- Upheld (Agree)
- Overturned (Disagree)
- Partially Overturned (Agree in part/Disagree in part)

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

Type of Document Received	Date(s) of Record

**EMPLOYEE CLINICAL HISTORY [SUMMARY]:**

This is a male who sustained injury on xx/xx/xx. He reported injury to his head, neck, back and right shoulder. The treatment history includes physical therapy, pain medications,



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work restrictions, and subacromial injection. His surgical history includes right decompressive Neer acromioplasty with Mumford procedure and rotator cuff repair on 05/30/2013. He had MRI dated 10/30/2013 that showed surgical changes of the acromion and AC joint with associated metal artifact, no rotator cuff tear but some rotator cuff tendinosis, partial longitudinal tear of biceps tendon, and SLAP tear. A most recent progress report dated 02/07/2014 indicates that has done satisfactory since his surgery but no improvement in range of motion. reported pain with extreme motions especially with abduction, IR and ER. did x-rays that showed emphatically some ectopic bone formation between the clavicle and acromion as well as impingement of the humeral head. There was posterior hypertrophy of the acromion impinging his motion particularly abduction and IR. recommended decompression of the subacromial and ectopic bone to improve range of motion.

## **ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION.**

This patient developed a rare complication after routine shoulder arthroscopy, subacromial decompression, distal clavicle resection, and rotator cuff repair. There are numerous case reports in the peer reviewed literature describing this complication occurring specifically in the setting of shoulder arthroscopy and rotator cuff repair (Kircher J, Martinek V, Mittelmeier W. Arthroscopy. 2007 Dec;23(12):1359.e1-3. Epub 2007 Feb 14., Matsumoto I, Ito Y, Tomo H, Nakao Y, Takaoka K. Clin Orthop Relat Res. 2005 Aug;(437):247-50., Berg EE, Ciullo JV, Oglesby JW. Arthroscopy. 1994 Apr;10(2):158-61.) It does not appear that the ODG offers guidance for management of this specific condition. The patient has undergone a full postoperative course of physical therapy after surgery, and he has developed a mechanical block to range of motion visible of radiographs. He is now over 1 year out from his index surgery which should be adequate time for the heterotopic ossification to mature. I do not anticipate that additional conservative treatments such as more physical therapy, subacromial injections, etc. will help restore range of motion or relieve pain in the setting of a mechanical block to motion. The case reports above demonstrate overall good clinical outcomes after surgical excision of heterotopic bone. As such, I would conclude that surgical excision of HO now over 1 year out from index surgery is a reasonable intervention for this patient that is supported by current clinical literature.

### **ODG – SHOULDER CHAPTER SURGERY FOR IMPINGEMENT SYNDROME**

Recommended as indicated below. Surgery for impingement syndrome is usually arthroscopic decompression (acromioplasty). However, this procedure is not indicated for patients with mild symptoms or those who have no limitations of activities. Conservative care, including cortisone injections, should be carried out for at least three to six months prior to considering surgery. Since this diagnosis is on a continuum with other rotator cuff conditions, including rotator cuff syndrome and rotator cuff tendonitis, see also Surgery for rotator cuff repair. (Prochazka, 2001) (Ejnisman-Cochrane, 2004) (Grant, 2004) Arthroscopic subacromial decompression does not appear to change the functional outcome after arthroscopic repair of the rotator cuff. (Gartsman, 2004) This systematic review comparing arthroscopic versus open acromioplasty, using data from four Level I and one Level II randomized controlled trials, could not find appreciable differences between arthroscopic and open surgery, in all measures, including pain, UCLA



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shoulder scores, range of motion, strength, the time required to perform surgery, and return to work. (Barfield, 2007) Operative treatment, including isolated distal clavicle resection or subacromial decompression (with or without rotator cuff repair), may be considered in the treatment of patients whose condition does not improve after 6 months of conservative therapy or of patients younger than 60 years with debilitating symptoms that impair function. The results of conservative treatment vary, ongoing or worsening symptoms being reported by 30-40% patients at follow-up. Patients with more severe symptoms, longer duration of symptoms, and a hook-shaped acromion tend to have worse results than do other patients. (Hambly, 2007) A prospective randomised study compared the results of arthroscopic subacromial bursectomy alone with debridement of the subacromial bursa followed by acromioplasty in patients suffering from primary subacromial impingement without a rupture of the rotator cuff who had failed previous conservative treatment. At a mean follow-up of 2.5 years both bursectomy and acromioplasty gave good clinical results, and no statistically significant differences were found between the two treatments. The authors concluded that primary subacromial impingement syndrome is largely an intrinsic degenerative condition rather than an extrinsic mechanical disorder. (Henkus, 2009) A recent RCT concluded that arthroscopic acromioplasty provides no clinically important effects over a structured and supervised exercise program alone in terms of subjective outcome or cost-effectiveness when measured at 24 months, and that structured exercise treatment should be the basis for treatment of shoulder impingement syndrome, with operative treatment offered judiciously. (Ketola, 2009)

ODG Indications for Surgery -- Acromioplasty:

Criteria for anterior acromioplasty with diagnosis of acromial impingement syndrome (80% of these patients 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 ROM, which requires both stretching and strengthening to balance the musculature. PLUS
  2. Subjective Clinical Findings: Pain with active arc motion 90 to 130 degrees. AND Pain at night. PLUS
  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). PLUS
  4. Imaging Clinical Findings: Conventional x-rays, AP, and true lateral or axillary view. AND Gadolinium MRI, ultrasound, or arthrogram shows positive evidence of impingement.
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**A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER  
CLINICAL BASIS USED TO MAKE THE DECISION:**

- ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE
- AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES
- DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES
- EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN
- INTERQUAL CRITERIA
- MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS
- MERCY CENTER CONSENSUS CONFERENCE GUIDELINES
- MILLIMAN CARE GUIDELINES
- ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**
- PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR
- TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS
- TEXAS TACADA GUIDELINES
- TMF SCREENING CRITERIA MANUAL
- PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)**
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**

(Kircher J, Martinek V, Mittelmeier W. Arthroscopy. 2007 Dec;23(12):1359.e1-3. Epub 2007 Feb 14., Matsumoto I, Ito Y, Tomo H, Nakao Y, Takaoka K. Clin Orthop Relat Res. 2005 Aug;(437):247-50., Berg EE, Ciullo JV, Oglesby JW. Arthroscopy. 1994 Apr;10(2):158-61.)