

<b>Case Number:</b>	CM15-0143726		
<b>Date Assigned:</b>	08/04/2015	<b>Date of Injury:</b>	02/04/2015
<b>Decision Date:</b>	09/16/2015	<b>UR Denial Date:</b>	06/18/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/24/2015

### 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:

This injured worker is a 28-year-old male who sustained an industrial injury on 2/4/15, relative to his regular work duties as an auto technician. Conservative treatment included activity modification, anti-inflammatory medications, Norco, physical therapy, corticosteroid injection, and home exercise. The 2/4/15 left shoulder x-rays revealed no disarticulation at the glenohumeral joint, no acute bony pathology of fracture, and no definitive acromioclavicular (AC) separation, but clinical consideration warranted. The 5/8/15 left shoulder MR arthrogram demonstrated a Buford complex. He had a cordlike middle glenohumeral ligament arising with the superior glenohumeral ligament. The anterior superior labrum was absent. The 6/8/15 orthopedic report cited continued left shoulder pain with popping, snapping, and weakness. Left shoulder exam documented anterior pain to palpation. Range of motion was documented as forward flexion 180, abduction 170, external rotation 60, internal rotation 80, and extension 50 degrees. There was clicking and pain with forward flexion. The diagnosis was Buford complex left shoulder and left biceps tendinosis. The injured worker was doing home exercise but he had apprehension and pain with the exercises and had been unable to rehab his shoulder. The treatment plan recommended arthroscopy to evaluate the left shoulder, followed by a repair or reconstruction of the labrum if possible. However, if the Buford complex compromised the reconstruction in the front of the shoulder, a Bristow procedure would be performed. Authorization was requested for a left shoulder arthroscopy with possible ligament reconstruction and Bristow procedure. The 6/18/15 utilization review non-certified the request for left shoulder arthroscopy with possible ligament reconstruction and Bristow procedure as there was no objective clinical findings of left shoulder instability/subluxation, documentation noting AC joint pain or tenderness, or a previous AC separation.

## **IMR ISSUES, DECISIONS AND RATIONALES**

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

### **Left shoulder arthroscopy with possible ligament reconstruction and bristow procedure:**

Overtured

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines, Shoulder, Surgery for shoulder dislocation.

**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: Diagnostic arthroscopy; Surgery for SLAP lesions.

**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 (ODG) recommend diagnostic arthroscopy in cases where imaging is inconclusive and acute pain or functional limitation continues despite conservative care. The ODG recommend surgery for SLAP lesions after 3 months of conservative treatment, and when history, physical exam, and imaging indicate pathology. Guidelines state definitive diagnosis of SLAP lesions is diagnostic arthroscopy. Guideline criteria have been met. This injured worker presents with persistent and function-limiting pain precluding return to work. Clinical exam findings are consistent with imaging evidence of labral pathology and a Buford complex. Detailed evidence of 4 months of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has been submitted. Therefore, this request is medically necessary.