

<b>Case Number:</b>	CM14-0115409		
<b>Date Assigned:</b>	08/04/2014	<b>Date of Injury:</b>	09/15/2009
<b>Decision Date:</b>	09/15/2014	<b>UR Denial Date:</b>	07/08/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/23/2014

### 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 Orthopedic Surgery, and is licensed to practice in California. 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 claimant is a 67-year-old who injured the right shoulder and neck in work related accident on 09/15/09. Clinical records provided for review include the report of a cervical MRI dated 01/09/14 that revealed at the C5-6 level diffuse disc osteophyte complex with moderate neuroforaminal stenosis and at the C6-7 level also diffuse disc osteophyte complex with moderate neuroforaminal narrowing. The report of an MRI of the right shoulder dated May 30, 2014 identified a full thickness tear of the supraspinatus and infraspinatus tendons with retraction and atrophy. The progress report of July 22, 2014 noted neck complaints, radiating right shoulder pain and headaches. Physical examination showed restricted cervical range of motion in all directions, restricted right shoulder range of motion and 90 degrees of flexion and abduction. There was 5-/5 right shoulder abductor strength and no documentation of sensory or reflexive changes. The claimant was diagnosed with partial thickness rotator cuff tear; there was no diagnosis for the neck symptoms. The June 10, 2014 assessment noted neck, shoulder and headaches complaints with objective findings the same as documented in the July assessment. Diagnosis at the June assessment was cervical spine disc syndrome and a two level C5-6 and C6-7 fusion was recommended. This review is for right shoulder surgery, cervical fusion, right shoulder PRP injections, and topical medications.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Right Shoulder Arthroscopy with Repairs Anterior Cervical Discectomy and Fusion at C5-C6 and C6-C7: 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): Diagnostic Arthroscopy, Fusion Anterior Cervical.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 9 Shoulder Complaints Page(s): 180; 210-211.

**Decision rationale:** Based on the California ACOEM Guidelines the request for right shoulder arthroscopy with repair and an anterior cervical discectomy and fusion at C5-C6 and C6-C7 cannot be recommended as medically necessary. ACOEM Guidelines recommend a trial of conservative treatment. There is no documentation in the records provided for review of recent conservative care for the shoulder to acutely support the need for shoulder arthroscopy and "repairs". In this case, rotator cuff repair would not be indicated based on the MRI findings of a large amount of retraction and atrophy indicative of chronic tendon tearing. The acute need of rotator cuff repair in the setting of significant retraction and atrophy without conservative measures would not be indicated. The second part of the proposed surgery, anterior cervical discectomy and fusion of C5-C6 and C6-C7 also cannot be supported as there is no imaging evidence or examination findings indicating instability to require a fusion. ACOEM Guidelines state that the efficacy of cervical fusion for patients with chronic cervical pain without instability has not been demonstrated. Therefore, based on the ACOEM Guidelines and the medical records provided for review, the request for right shoulder arthroscopy with repair and an anterior cervical discectomy and fusion at C5-C6 and C6-C7 cannot be recommended as medically necessary.

**TGHOT Cream (Quantity and Strength not Specified):** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

**Decision rationale:** California MTUS Chronic Pain Medical Treatment Guidelines do not support the topical compound TG HOT. The documentation provided for review does not identify the specific compound agents that make up this cream. Chronic Pain Guidelines recommend that topical compound agents are largely experimental with few randomized clinical controlled trials demonstrating their efficacy and/or effectiveness. The request for this agent for which specific compounding agents are not noted would not be supported. Therefore, request for TGHOT Cream is not medically necessary.

**Topical FlurFlex Cream (Quantity and Strength not Specified):** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

**Decision rationale:** California MTUS Chronic Pain Medical Treatment Guidelines would also not support Fluoroplex topical cream. Chronic Pain Guidelines indicate that topical compounds are largely experimental with few randomized clinical controlled trials demonstrating their efficacy or effectiveness. The use of this agent which contains Flurbiprofen and a muscle relaxant would fail to meet the Chronic Pain Guidelines as muscle relaxants and topical nonsteroidal agents other than Diclofenac are not supported for topical use. The request in this case would fail to support guideline criteria. Therefore, the request for Topical FlurFlex Cream is not medically necessary.

**Right Shoulder Open Rotator Cuff Repair PRP Injections:** 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): Surgery Rotator Cuff Repair.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 210. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG); Treatment in Worker's Comp, 18th Edition, 2013 Updates: shoulder procedure Platelet-rich plasma (PRP).

**Decision rationale:** California ACOEM Guidelines supported by the Official Disability Guidelines do not support the request for right shoulder open rotator cuff repair and PRP injection. The need for rotator cuff repair was also requested in question number one which was not supported. As stated, rotator cuff repair would not be indicated based on the MRI findings of a large amount of retraction and atrophy indicative of chronic tendon tearing. The acute need of rotator cuff repair in the setting of significant retraction and atrophy without conservative measures would not be indicated. In addition to the surgery, the request for PRP injection is also not recommended. The Official Disability Guidelines currently do not support the use of PRP in the shoulder in the postsurgical or chronic treatment stages. The request for surgical process to include PRP injection would not be indicated. The request for Right Shoulder Open Rotator Cuff Repair PRP Injections is not medically necessary.

**Tramadol 50 mg (Quantity Not Specified):** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Tramadol (Ultram).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids-Tramadol (Ultram) Page(s): 75, 80-84, 91-94.

**Decision rationale:** California MTUS Chronic Pain Guidelines do not support the use of Tramadol. The Chronic Pain Guidelines do not recommend the use of Tramadol beyond sixteen

weeks for pain complaints. The lack of support for the use of Tramadol beyond sixteen weeks does not support the request for continued use. Therefore, Tramadol is not medically necessary.