

<b>Case Number:</b>	CM15-0066053		
<b>Date Assigned:</b>	04/13/2015	<b>Date of Injury:</b>	12/02/2012
<b>Decision Date:</b>	05/15/2015	<b>UR Denial Date:</b>	03/04/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/07/2015

### 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 63-year-old female who sustained an industrial injury on 12/2/12. Injury occurred when she slipped and fell while carrying a heavy pot of food. Past medical history was positive for diabetes, hypertension, and bilateral hand arthritis. The 10/10/14 right shoulder MRI impression documented a 1 cm tear of the supraspinatus tendon, 4 cm proximal to the insertion site and greater tuberosity, with fluid in the subacromial/subdeltoid bursa indicating a full thickness tear. Conservative treatment included chiropractic, physical therapy, acupuncture, and medications. Surgery for the right shoulder, including rotator cuff repair, subacromial decompression, distal clavicle resection, and biceps repair had been requested since 10/29/14. The 2/17/15 treating physician report cited worsening right shoulder pain grade 8/10. An orthopedic consultant had recommended right shoulder surgery. She had on-going right shoulder pain and weakness since the date of injury. Physical exam documented right shoulder range of motion with flexion 120, abduction 100, internal rotation 70, external rotation 70, and adduction 40 degrees. There was shoulder flexion and abduction weakness. The treating physician requested authorization for right shoulder arthroscopy and FCL compound cream (Flurbiprofen 20%/Tramadol 20% 180 grams). The 3/4/15 utilization review non-certified the request for right shoulder arthroscopy as there was no surgical request from the operating surgeon, no updated shoulder MRI report, no evidence that she had failed to respond to recent physical therapy, no evidence of injection therapy and response, and no evidence of night pain or painful arc of motion. The request for FCL compound cream was non-certified based on no documentation that the injured worker failed to respond to oral non-steroidal anti-inflammatory (NSAIDs)

medications or was intolerant of oral NSAIDs. Additionally there was no documentation that the compound requested was FDA approved or that tramadol was efficacious in a topical formulation. The 3/7/15 orthopedic report cited on-going right shoulder pain minimally relieved with physical therapy and not relieved with oral medications. She had a rotator cuff tear and would like surgery as soon as it's authorized. Right shoulder exam documented positive weakness with limited range of motion, including flexion 140 degrees, abduction 120 degrees, external rotation 50 degrees, and internal rotation to the sacrum. The diagnosis was right shoulder rotator cuff syndrome, adhesive capsulitis, tendinitis, and arthritis. The injured worker had a full thickness rotator cuff tear and pain with activities of daily living. She had failed conservative treatment. Authorization was requested for shoulder arthroscopy, rotator cuff repair, subacromial decompression, distal clavicle resection, and biceps surgery. She was unable to work at this time.

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

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

#### **Right Shoulder Arthroscopy: Overturned**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Rotator cuff repair.

**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 rotator cuff repair.

**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. For partial thickness rotator cuff tears and small full thickness tears presenting as impingement, surgery is reserved for cases failing conservative treatment for 3 months. The Official Disability Guidelines for rotator cuff repair with a diagnosis of full thickness tear typically require clinical findings of shoulder pain and inability to elevate the arm, weakness with abduction testing, atrophy of shoulder musculature, and positive imaging evidence of rotator cuff deficit. Guideline criteria have been reasonably met. The injured worker presents with persistent function-limiting and constant right shoulder pain and weakness. Clinical exam findings documented loss of range of motion and weakness in abduction and forward flexion. There is imaging evidence of a full thickness rotator cuff tear. Evidence of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has been submitted. Therefore, this request is medically necessary.

#### **FCL Compound Cream (Flurbiprofen 20%/Tramadol 20%, 180 grams): Upheld**

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

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

**Decision rationale:** The California MTUS guidelines state that topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. Topical agents are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. There is little to no research to support the use of many of these agents. Guidelines state that any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Guidelines do not recommend topical non-steroid anti-inflammatory drugs (NSAIDs) for neuropathic pain and state there is little evidence to utilize topical NSAIDs for treatment of osteoarthritis of the spine or shoulder. Flurbiprofen is not on the list of approved topical non-steroidal anti-inflammatory drugs. There are no high-quality literary studies or guidelines which support the safety or efficacy of tramadol utilized topically. Given the absence of guideline support for all components of this product, this product is not recommended by guidelines. Therefore, this request is not medically necessary.