

<b>Case Number:</b>	CM14-0018412		
<b>Date Assigned:</b>	04/18/2014	<b>Date of Injury:</b>	09/13/2010
<b>Decision Date:</b>	07/08/2014	<b>UR Denial Date:</b>	01/10/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/13/2014

### 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 53-year-old female injured in a work-related accident on September 13, 2010. An MRI scan dated January 10, 2013, revealed C5-6 foraminal narrowing, left greater than right, and disc bulging; at C6-7 posterior disc bulging without evidence of canal foraminal narrowing or encroachment. The claimant's most recent clinical assessment, dated March 6, 2014, documents continued complaints of neck pain, radiating pain to the bilateral shoulders, and pain to the mid back. Physical examination showed restricted cervical range of motion with dizziness. Neurologic examination was not documented. The claimant's diagnoses were cervical radiculopathy, neck pain, bilateral shoulder pain with impingement and internal derangement. The claimant was noted to have failed conservative measures, including medication management, injection therapy, and physical and occupational therapy. This request is for: a C5-6 and C6-7 anterior discectomy and fusion; an assistant surgeon; a one-day inpatient hospital stay; a bone growth stimulator; a cervical collar; and Ketoprofen.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**C5-C6, C6-C7 ANTERIOR DISCECTOMY FUSION, PLATING:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Page(s): 180.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 180.

**Decision rationale:** Based on California ACOEM Guidelines, a two-level anterior cervical discectomy and fusion would not be indicated in this case. The records do not document any indication of compressive pathology upon examination or focal motor, sensory or reflexive change correlating to the requested levels of surgery. Furthermore the claimant's prior imaging does not demonstrate specific compressive pathology at the requested levels of C5-6 and C6-7. Absent such findings, the request for two-level fusion would not be medically indicated.

**WITH ASSISTANT SURGEON:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**1 DAY INPATIENT STAY AT [REDACTED]:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**BONE GROWTH STIMULATOR:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**ONE CERVICAL COLLAR:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**KETOPROFEN MILD (CAPSAICIN/BACLOFEN/KETOPROFEN) 240MG:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines COMPOUNDED MEDICATIONS Page(s): 111.

**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 not support the role of topical compound containing Capsaicin, Baclofen and Ketoprofen. Ketoprofen is a non-FDA-approved for topical use. Therefore, this request for its use would not be medically indicated.