

<b>Case Number:</b>	CM14-0173165		
<b>Date Assigned:</b>	10/23/2014	<b>Date of Injury:</b>	04/30/2002
<b>Decision Date:</b>	11/25/2014	<b>UR Denial Date:</b>	10/16/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/20/2014

### 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 Spine Surgery and is licensed to practice in Texas. 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 injured worker is a 61-year-old male who reported an injury on 04/30/2002. The mechanism of injury was not provided. On 07/25/2014, the injured worker presented with numbness and tingling in the right upper extremity and weakness in the right upper extremity. Diagnoses were chronic cervical spine sprain with bilateral C6 radiculopathy, overuse syndrome of the bilateral upper extremities, left shoulder impingement syndrome, right shoulder impingement syndrome, bilateral elbow sprain with lateral medial epicondylitis, bilateral carpal tunnel syndrome, and gastritis. An EMG/NCV performed on 03/17/2014 revealed mild left C5-6 radiculopathy. Prior therapies included medications and cortisone injections into the cervical spine. The provider recommended a cervical discectomy and fusion, naproxen cream, and a topical analgesic. There was no rationale provided. The Request for Authorization was not included in the medical documents for review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

#### **1 Cervical Discectomy and Fusion at C3-C6: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines Neck and Upper Back (Acute & Chronic) Fusion, Anterior Cervical

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 179-180.

**Decision rationale:** The request for 1 cervical discectomy and fusion at C3-C6 is not medically necessary. The California MTUS/ACOEM Guidelines state that the efficacy of cervical fusion for injured workers with chronic cervical pain without instability has not been demonstrated. If surgery is a consideration, counseling and discussion regarding likely outcomes, risks and benefits, and especially expectations is essential. Injured workers with acute neck and upper back alone, without findings of serious conditions or significant root compromise rarely benefit from either surgical consultation or surgery. If there is no clear indication for surgery, referring the injured worker to a physical medicine and rehabilitation specialist may help resolve symptoms. The clinical documentation submitted for review lacked evidence of instability upon physical examination. Additionally, there is a lack of documentation of failed conservative treatments to include medication and physical therapy noted in the documents submitted for review. As such, medical necessity has not been established.

**Cyclo/Keto/Lido 240 Gm with 1 Refill:** 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.

**Decision rationale:** The request for cyclo/keto/lido 240 gm with 1 refill is not medically necessary. The California MTUS Guidelines state that transdermal compounds are largely experimental in use with few randomized control trials to determine efficacy or safety. Topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Any compounded product that contains at least 1 drug (or drug class) that is not recommended, is not recommended. Many agents are compounded as monotherapy in combination for pain control, including NSAIDs, opioids, capsaicin, local anesthetics, and antidepressants. There is little to no research to support the use of many of these agents. The provider's request did not indicate the site at which the cream was indicated for or the frequency of the medication in the request as submitted. As such, medical necessity has not been established.

**Naproxen Cream 60 GM with 1 Refill:** 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.

**Decision rationale:** The request for naproxen cream 60 gm with 1 refill is not medically necessary. The California MTUS Guidelines state that transdermal compounds are largely

experimental in use with few randomized control trials to determine efficacy or safety. Topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Any compounded product that contains at least 1 drug (or drug class) that is not recommended, is not recommended. Many agents are compounded as monotherapy in combination for pain control, including NSAIDs, opioids, capsaicin, local anesthetics, and antidepressants. There is little to no research to support the use of many of these agents. The provider's request did not indicate the site at which the cream was indicated for or the frequency of the medication in the request as submitted. As such, medical necessity has not been established.