

<b>Case Number:</b>	CM13-0044457		
<b>Date Assigned:</b>	12/27/2013	<b>Date of Injury:</b>	08/02/2005
<b>Decision Date:</b>	04/14/2014	<b>UR Denial Date:</b>	10/02/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/29/2013

### 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:

This 54-year-old male firefighter sustained cumulative trauma to the neck, low back, bilateral knees, left shoulder, and bilateral feet, as well as hearing loss, while employed by the [REDACTED]. The date of injury is 8/02/05. The patient was status post C5/6 anterior cervical decompression and fusion in 1997 and right total knee replacement in June 2012. The 7/2/13 treating physician report cited continued cervical symptomatology. Cervical spine exam documented cervical paravertebral and upper trapezius muscle spasms, positive axial loading and Spurling's maneuver, painful and restricted cervical range of motion, and dysesthesia at the C5 and C7 dermatomes on the left. The diagnosis included status post C5/6 ACDF with C4/5 and C6/7 severe junctional level pathology and retained symptomatic cervical hardware C4/5. The 7/2/13 pre-operative clearance reported documented past medical history was positive for hypertension and hyperlipidemia. ECG, pulmonary function tests and chest x-ray were within normal limits. Lab results were remarkable for an elevated fasting glucose. The 7/2/13 echocardiogram report documented mild dilated left atrium, mild thickening of the mitral valve with normal leaflet separation, mitral regurgitation 1+, tricuspid regurgitation 1+, and left ventricular inflow pattern suggestive of mild diastolic dysfunction. The patient was classified as a Goldman Class 1 for the proposed surgery. On 7/4/13, the patient underwent removal of anterior cervical hardware at C5/6, anterior cervical microdiscectomy at C3/4, C4/5, and C6/7, implantation of dynamic intervertebral implant at C3/4, and anterior C4/5 and C6/7 fusion with instrumentation. The 7/5/13 internal medicine inpatient consultation noted the patient was in the spinal unit and his cardiopulmonary status was being very closely monitored. Vital signs included blood pressure 125/75, respirations 17, heart rate 77 and oxygen saturation was 95% on 2 liters of oxygen. The treatment plan was continued monitoring and adequate pain control. The

patient was discharged on 7/6/13 following an uneventful hospital course during which he remained hemodynamically stable.

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

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

#### **INPATIENT STAY X 2 DAYS (ADDITIONAL): Overturned**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG), TWC NECK AND UPPER BACK PROCEDURE SUMMARY.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG) NECK AND UPPER BACK, HOSPITAL LENGTH OF STAY (LOS).

**Decision rationale:** Under consideration is a request for additional 2 day inpatient stay. The California MTUS guidelines do not provide hospital length of stay recommendations. The Official Disability Guidelines for anterior cervical fusion hospital length of stay indicate the median is 1 day, mean is 2.2 days, and best practice target is 1 day. The guidelines indicate that for retrospective benchmarking, the mean may be a better choice. This patient underwent a C3-C7 hybrid reconstruction on 7/4/13 including hardware removal at C5/6, anterior cervical discectomy C3/4, C4/5, and C6/7, dynamic intervertebral implant at C3/4, and anterior C4/5 and C6/7 fusion with instrumentation. He was subsequently discharged on 7/6/13 with no post-operative complications. The use of the mean length of stay recommendation for this level of cervical surgery is essentially consistent with guidelines. Therefore, this request for additional 2 day inpatient stay was medically necessary.