

<b>Case Number:</b>	CM14-0066790		
<b>Date Assigned:</b>	07/11/2014	<b>Date of Injury:</b>	08/25/2009
<b>Decision Date:</b>	08/25/2014	<b>UR Denial Date:</b>	05/02/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/09/2014

### 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 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 43 year old female who had a work-related injury on 08/25/09. The mechanism of injury is not documented. The injured worker complained of chronic neck pain with a history of anterior cervical fusion at C5-6 in October of 2011 but continued with neck and bilateral upper extremity pain. She was treated conservatively with physical therapy, medication and facet injections. On 03/20/14, the injured worker complained of bilateral neck pain and examination showed tenderness to palpation in the paraspinal muscle region and a decreased range of motion throughout. Motor strength was 5/5, and there were no long track signs. MRI of the cervical spine was done on 07/26/13 that showed anterior decompression and fusion in good alignment at C5-6 with no residual central foraminal stenosis. At C4-5, a 1mm central disc protrusion caused mild central stenosis, and there was moderate left and mild right C4-5 foraminal stenosis due to bony degenerative disease. There was no evidence of bone fusion across the fused C5-6 disc space by MRI similar to CT appearance. Prior utilization review on 05/02/14 the anterior cervical discectomy and fusion with autograph, remove hardware and remove cage at C4-6 was certified. The hospital stay was modified from 3 days to 1 day.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**3 day inpatient:** 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),

Treatment Index, 12th Edition (web), 2014, Neck and upper Back- Fusion, anterior cervical, Pseudoarthrosis; Hospital length of stay (LOS).

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck chapter, Hospital length of stay (LOS).

**Decision rationale:** The request for 3 day inpatient is not medically necessary. Prior utilization review on 05/02/14 modified to 1 day inpatient stay. Current guidelines for Anterior Cervical Fusion states median one day, therefore the request of 3 day inpatient is not medically necessary and appropriate.