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| Case Number: | CM15-0190464 | | |
| Date Assigned: | 10/02/2015 | Date of Injury: | 07/08/2013 |
| Decision Date: | 11/16/2015 | UR Denial Date: | 09/01/2015 |
| Priority: | Standard | Application Received: | 09/28/2015 |

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:

This injured worker is a 50-year-old female who sustained an industrial injury on 7/8/13, relative to cumulative trauma. Past medical history was negative. The 11/20/13 EMG/NCV study documented electrodiagnostic evidence of chronic left C5 radiculopathy. There was no evidence of upper extremity peripheral neuropathy. The 4/16/15 treating physician report cited neck, back, and bilateral shoulder, elbow, wrist, and hand pain. Cervical range of motion was significantly limited and painful. There was 4/5 to 4-/5 bilateral deltoid, biceps, triceps, wrist extensor, wrist flexor and interosseous weakness, and 4/5 right and 4+/5 left opponens pollicis longus weakness. Grip strength was 4+/5 bilaterally. There was decreased sensation over the bilateral C6 and left C7 and C8 dermatomes, positive Hoffman's sign on the left, and 2+ and symmetrical reflexes. The cervical spine MRI on 1/20/14 demonstrated central disc herniations at C3/4 and C6/7 with spinal cord impingement. There was increased T2 signal hyperintensity within the spinal cord particularly at the C3/4 level, indicating some myelomalacia. The injured worker was diagnosed with C3/4 and C6/7 disc herniation with marked foraminal stenosis and spinal cord compression. The treatment plan recommended anterior cervical discectomy and fusion at C3/4 and C6/7. Authorization was requested for C3/4 and C6/7 anterior cervical discectomy and fusion with 2-day inpatient stay on 5/29/15. The injured worker underwent anterior cervical discectomy and fusion at C3/4 and C6/7 on 8/24/15. The 8/24/15 case management review worksheet indicated that the injured worker was a direct admission for anterior cervical discectomy and fusion with stem cells. Pre-operative EKG showed positive T wave abnormality. Initial post-operative physician orders included intravenous Ancef, neuro checks every 2 hours, physical therapy,

intravenous Zofran, intramuscular Morphine, Dilaudid (patient controlled analgesia) and pain consult. The 8/25/15 chart note indicated the injured worker was in the ICU with blood pressure 177/90 and complained of severe grade 9/10 pain. Lab results documented white blood cell (WBC) 16,934, hemoglobin 11.8, and hematocrit 32.8. Intravenous (IV) fluids were continued, and oxygen was provided by nasal cannula. Pain medications included Percocet and intramuscular (IM) morphine. The 8/26/15 chart note indicated that the injured worker was in the ICU and could not be transferred yet and required one more ICU day. She had severe pain, difficulty swallowing, and was easily fatigued. Lab results documented WBC 15,924, hemoglobin 11.5, and hematocrit 32.8. IV fluids were continued and the injured worker remained on oxygen. Medications included IM morphine and Percocet. Physical therapy ambulated the injured worker with assistance, and she tolerated only 50 feet. There were no additional operative or hospital records submitted for review beyond 8/26/15. Authorization was requested for 4 additional days of an inpatient stay. The 9/1/15 utilization review non-certified the request for 4 additional inpatient days as there was no documentation of a complication to support the medical necessity of inpatient admission beyond the 2-day inpatient stay previously certified and consistent with guidelines.

IMR ISSUES, DECISIONS AND RATIONALES

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

Additional 4 days in patient: 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), Neck & Upper Back (updated 06/25/15).

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: The California MTUS does not provide hospital length of stay recommendations. The Official Disability Guidelines recommend the median length of stay (LOS) based on type of surgery, or best practice target LOS for cases with no complications. The recommended median and best practice target for anterior cervical fusion is 1 day. The mean length of stay was 2.2 days for anterior cervical fusion. Guideline criteria have not been met. This injured worker underwent anterior cervical discectomy and fusion at C3/4 and C6/7 on 8/25/15 and was a direct admit to the ICU. Records indicated that continued intensive care was recommended for one additional day on 8/26/15. Additional inpatient treatment would be supported based on the records reviewed. However, this request would cover 4 additional days of inpatient care, and there are no supporting records to establish the medical necessity of that care. Therefore, this request is not medically necessary.