

Case Number:	CM15-0179372		
Date Assigned:	09/21/2015	Date of Injury:	12/05/2007
Decision Date:	10/28/2015	UR Denial Date:	09/02/2015
Priority:	Standard	Application Received:	09/11/2015

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: Minnesota, Florida

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:

The injured worker is a 61-year-old male, who sustained an industrial injury on 12-05-2007. The injured worker was being treated for chronic intractable axial neck pain, left sided facial pain, left radiating arm pain, status post anterior cervical fusion presumably C4-C6 (8-2011) with subsequent posterior spinal fusion and instrumentation C4-T1 (2013), with subsequent wound dehiscence and revision surgery (3-2013), chronic pain management, rule out cervical instability and stenosis, and rule out permanent nerve root damage and peripheral neuropathy. Treatment to date has included diagnostics, multiple cervical spinal surgeries, physical therapy, and medications. Currently (8-21-2015), the injured worker complains of "severe" neck pain with radiation down his left arm, with numbness and weakness in his left arm and hand. He reported that left hand weakness started post-cervical myelogram computerized tomography (documented to show "large disc herniation at C3-4 as well as canal stenosis"). X-rays were documented to show "C4-5 and C5-6 screws have backed out". Medications were listed as "none". Exam of the cervical spine noted pain on palpation of the cervical paraspinal and trapezial musculature. Range of motion noted zero extension. Motor exam of the upper extremities noted 5 of 5 strength in the right and 3 of 5 left biceps, 4 of 5 left triceps, 3 of 5 in left wrist flexors and extensors, and 3 of 5 in the left interossei muscles. Diminished sensation was noted throughout the left arm from C5 down to T1 dermatome, intact in the right C5 to T1. The treatment plan, per the request for authorization dated 8-25-2015 included anterior cervical discectomy and fusion at C3-C4, possible C4-5, removal of instrumentation at C4-C6 (certified),

and associated surgical services. The request for 2-day inpatient stay was modified to 1 day and the request for post-operative home health RN visits x8 was modified to 4 by Utilization Review on 9-02-2015.

IMR ISSUES, DECISIONS AND RATIONALES

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

LOS: inpatient x 2 days: 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 and Upper Back, LOS.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG: Section: Neck and upper back, Topic: Hospital length of stay.

Decision rationale: California MTUS does not address this topic. According to ODG guidelines, the hospital length of stay for anterior cervical fusion is a median of one day and best practice target with no complications 1 day. The request as stated is for 2 days, which is not supported by evidence-based guidelines and as such, the medical necessity of the request has not been substantiated. This request is not medically necessary.

Post-op home health RN visits x 8: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Home health services.

Decision rationale: Home health services are recommended only for otherwise recommended medical treatment for patients who are homebound, on a part-time or intermittent basis. The request as stated is for 8 nursing visits. There is no documentation provided as to why the injured worker will be homebound and not able to travel to his appointments for 8 days. As such, the medical necessity of the request has not been substantiated. This request is not medically necessary.