

Case Number:	CM13-0029078		
Date Assigned:	11/01/2013	Date of Injury:	10/14/2008
Decision Date:	02/13/2014	UR Denial Date:	09/20/2013
Priority:	Standard	Application Received:	09/25/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician 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 physician 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 patient is a 52-year-old who was injured in a work related accident on 10/14/08. The specific request in this case is a retroactive request for a length of stay between 02/12/12 and 02/16/12 following lumbar L4 through S1 hardware removal with exploration of fusion. The records indicate the claimant underwent the initial surgical procedure on 10/11/10. The records indicate that following a course of postoperative care and documentation of failure to show advancement, the claimant was authorized for a hardware removal with exploration of fusion from L4 through S1. The surgical process apparently took place on 02/13/12. Operative report of 02/13/12 indicates that the claimant did undergo removal of hardware with exploration of mass and augmentation of fusion from L4 through S1. Postoperative clinical records reviewed include an internal medicine evaluation where he was noted to have a significant increase in numbness and weakness to his bilateral lower extremities in the postoperative period. Evaluation also stated that STAT CT imaging postoperatively showed soft tissue swelling and "pockets of air" at the surgical level. He had difficulty in controlling his postoperative pain. Further progress report of 02/15/12 as an inpatient showed the claimant had a drain removed with pain level slowly improving. Physical therapy began with advancement of ambulation. Therapist on 02/15/12 recommended one more day of therapy to "reinforce safety transfers from the bed for safe discharge home." A 02/16/12 assessment stated the claimant was doing significantly better, ambulating well, and was discharged home in stable condition.

IMR ISSUES, DECISIONS AND RATIONALES

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

retrospective request for inpatient length of stay 2/12/2012 to 2/16/2012 for lumbar hardware removal L4-S1 with exploration fusion mass: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Procedure Chapter.

Decision rationale: The California MTUS Guidelines are silent and when looking at the Official Disability Guidelines (ODG) criteria, the role of a fusion procedure would warrant typically a three day inpatient stay. The claimant's four day stay in this case would appear medically necessary given documentation from his inpatient treatment from 02/12/12 through 02/16/12. The claimant developed increased complaints of low back pain, weakness and numbness, for which postoperative imaging and medical management was warranted. He slowly advanced from a pain perspective as well as an ambulation perspective, where he was noted to be "not safe" for discharge on 02/15/12 physical therapy assessment. Following an additional day of therapy he was discharged home safely on 02/16/12. The role of an extra day of inpatient care for a four day total period of stay would appear to have been medically necessary given the documentation of inpatient records for review.