

Case Number:	CM13-0058235		
Date Assigned:	12/30/2013	Date of Injury:	12/05/1994
Decision Date:	04/03/2014	UR Denial Date:	10/25/2013
Priority:	Standard	Application Received:	11/26/2013

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 New York. 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 has a date of injury of December 5, 1994. He has chronic back pain. Physical examination reveals tenderness to palpation of the lumbar spine. There is a limited range of motion of the lumbar spine. There is slight decreased sensation of the L5 dorsum and S1 lateral right foot. He has positive straight leg raising on the right there. His MRI from October 2012 reveals central right-sided disc protrusion at L4-5 impinging on the thecal sac and right L5 nerve root causing mild to moderate central spinal stenosis. There is disc bulging at L2-3 and L3-4. There is facet arthropathy at L5-S1. The patient had another MRI in September 2013 that shows lateral recess stenosis at L2-3, disc degeneration at L3-4 and disc attenuation with osteophyte at L4-5 and L5-S1. There is moderate to severe right greater than left L4-5 lateral recess stenosis. The patient rates his pain at 6/10. He had steroid injections with temporary relief. He's also had medications. At issue is whether a 2 day inpatient stay is medically necessary in relation to decompression surgery (posterior bilateral L4-5 laminectomy and discectomy).

IMR ISSUES, DECISIONS AND RATIONALES

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

A two day inpatient stay: 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)

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 306. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Procedure.

Decision rationale: The guidelines indicate that single level lumbar laminectomy surgery that is uncomplicated may be performed as an outpatient basis. According to the Official Disability Guidelines, a 1 day hospital stay is the average length stay for an uncomplicated lumbar single level laminectomy decompressive surgery. The requested 2 day hospital stay after single level uncomplicated L4-5 laminectomy decompression is beyond guideline recommendations. Therefore, the requested 2 day inpatient hospital stay is not medically necessary or appropriate.