

Case Number:	CM14-0033406		
Date Assigned:	06/20/2014	Date of Injury:	09/03/2009
Decision Date:	07/23/2014	UR Denial Date:	02/20/2014
Priority:	Standard	Application Received:	03/17/2014

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 California. He/she has been in active clinical practice for more than five years and is currently working 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 patient is a 48-year-old female who was injured on September 3, 2009, when while climbing down from a step stool, she fell backwards. The patient is status post two-level fusion L4-S1 on May 3, 2011. The patient underwent removal of hardware with re-exploration of fusion, re-fusion and re-instrumentation on January 29, 2014. She underwent irrigation and debridement of the lumbar spine with wound closure on February 6, 2014. A prior UR determination February 20, 2014 recommended modification of the request of medical admission for postoperative liquefying hematoma (x 3 days), certify medical admissions for postoperative liquefying hematoma (x 2 days). The reviewer noted that there are no length of stay guidelines for wound drainage. It was determined that a two day length of stay could be considered reasonable for surgery and to evaluate the wound, with the patient likely maintained on intravenous antibiotics. At that time, it would be apparent that the patient could be discharged. It was unlikely that a three day length of stay would be necessary. According to the operative report dated February 6, 2014, irrigation and debridement of lumbar spine with wound closure was performed. Per the report, a few days after undergoing removal of hardware, L4 to S1 and posterolateral fusion L4-5, she began having a significant amount of drainage from the wound. She was admitted to the hospital for IV antibiotics and evaluation. After approximately 24-36 hours of IV antibiotics, she continued to drain from her wound. She had wound dehiscence over the middle aspect of her incision, which was actively draining serosanguineous fluid. Intraoperative findings: 1. Large, liquefied hematoma in the suprafascial and subfascial compartments with no evidence of frank infection, no purulence or gross evidence of infection. 2. Wound dehiscence and dehiscence of the skin, causing significant amount of drainage. Postoperative diagnosis: Status post removal of hardware and posterolateral fusion at L4-L5 L5-S1 with subsequent wound dehiscence, liquefied hematoma, and drainage from possible infection. According to the secondary treating physician's

progress report dated March 31, 2014 the patient complains of constant low back pain rated 8/10 with radiation to the bilateral lower extremities, associated with numbness. She reports she is unable to sit, stand or lay for long periods. Her current medications include Tylenol and topical creams. Examination of the lumbar spine reveals paraspinal spasms and tenderness. Incision is clean, dry and intact, there is no drainage or erythema. In addition, there is no sciatic notch tenderness. Motor strength testing reveals weakness in the extensor hallucis longus and tibialis anterior muscle groups. Diagnosis: status post removal of hardware and posterolateral fusion at L4 and L5 and L5-S1 and subsequent dehiscence, liquefied hematoma, and drainage from possible infection. The patient is to continue with home exercise program and spinal precautions, and begin postop physical therapy for the lumbar spine in 4 weeks. She will continue OTC Tylenol and topical medications.

IMR ISSUES, DECISIONS AND RATIONALES

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

Medical admission for post-operative liquefying hematoma QTY: 3.00: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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, Hospital length of stay (LOS).

Decision rationale: The Official Disability Guidelines, regarding hospital length of stay, recommend the median length of stay (LOS) based on type of surgery, or best practice target LOS for cases with no complications. For prospective management of cases, median is a better choice than mean (or average) because it represents the mid-point, at which half of the cases are less, and half are more. The patient underwent additional surgery on February 6, 2014 to drain a postoperative hematoma. She had been maintained on IV antibiotics during the days prior. According to the February 6, 2014 operative report, the procedure revealed a large, liquefied hematoma in the suprafascial and subfascial compartments with no evidence of frank infection, no purulence or gross evidence of infection. Based on the operative report, the medical records do not establish medical necessity for 3 day postop length of stay. The clinical findings support that a 2 day admission is sufficient in this case, for post-op evaluation and continued IV antibiotics (if indicated), followed by discharge home. The request is not medically necessary.