

Case Number:	CM14-0203099		
Date Assigned:	12/16/2014	Date of Injury:	01/14/2011
Decision Date:	02/04/2015	UR Denial Date:	12/01/2014
Priority:	Standard	Application Received:	12/04/2014

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 Internal Medicine 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 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 an injured worker with chronic low back pain. Date of injury was January 14, 2011. The hospital admission note dated June 5, 2014 documented a history of chronic lower back pain related to work injuries since 2011. She has been following with a pain management doctor, status post epidural. She was admitted from the emergency room for having intractable severe lower back pain. She describes her pain as over 10/10, unable to get up even to go to the bathroom and unable to move her legs. Because of the severity of the pain, the patient was advised to be admitted. The patient is known to have a history of back problems secondary to a work-related injury. She has been following a pain specialist. She had a few epidural injections with some improvement and she is taking some medication for back pain. Apparently two days ago, the patient sneezed. After sneezing, she started experiencing severe lower back pain. Pain was severe that she was unable to move from her bed to go to the bathroom. Her husband brought her to the emergency room. While she was in the emergency room, she was getting the benefit of Dilaudid and morphine. Despite that, her condition has not improved. Also, she was getting the benefit of Robaxin intravenous. Because of that, the patient was advised to be admitted for pain management issues, also to have magnetic resonance imaging. MRI magnetic resonance imaging shows a herniated disc, multilevel. Diagnosis was intractable lower back pain. The patient was admitted for pain management. Neurosurgeon report dated June 7, 2014 documented a chronic history of lumbar back pain dating back to 2011 where she was injured at work. She suffered with chronic lower back pain and periodic muscle spasms. The pain has become intractable making it difficult for her to move about or do simple activity. As a result, she came in through the emergency room. MRI magnetic resonance imaging of the lumbar spine demonstrated a central disc protrusion at L4-5 eccentric to the left. Diagnosis was intractable back pain and muscle spasms. Magnetic resonance scan of the lumbar spine report dated June 6,

2014 demonstrated that at L3-4, there is 2 mm broad-based bulging of the annulus fibrosis into the spinal canal. At L4-5, there is 4 mm protrusion of the disc into the left central spinal canal extending to the left lateral recess. There is mild narrowing of the intervertebral space and decreased T2 signal of nucleus pulposus. At L5-S1, the intervertebral disc appears normal, and there is no evidence of spinal canal or neural foraminal stenosis. Four mm protrusion of the L4-5 intervertebral disc into the left central spinal canal and lateral recess was noted. The hospital discharge summary from the date of admission June 5, 2014 to the date of discharge June 10, 2014 documented a history of chronic lower back pain. The patient presented to the emergency room for having intractable lower back pain. She was unable to get up and even to go to the bathroom. With minimal movement, she is experiencing severe muscle spasm in the entire spine and lower extremities. The patient was advised by the emergency room physician that she needed to be admitted to relieve her intractable back pain. The patient was admitted. She was given Morphine and Dilaudid intravenously. She was having severe muscle spasms. The patient was unable to get up to go to the bathroom. The patient was unable to get up. Intravenous Dilaudid, Morphine, and Robaxin was administered from June 5 through June 9, 2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective inpatient length of stay times 5 days DOS 06/05/2014-06/10/2014: Overturned

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 - Lumbar & Thoracic (Acute & Chronic) Hospital length of stay (LOS) Hospitalization

Decision rationale: Medical Treatment Utilization Schedule (MTUS) does not address hospital admission criteria. Official Disability Guidelines (ODG) presents hospital admission criteria. The primary valid reason for hospitalizing patients with back pain is that they cannot manage basic activities of daily living ADLs at home. Example, the patient lives alone and is unable to get to the bathroom. The need for parenteral narcotics is a valid admission criteria. The hospital admission note dated June 5, 2014 documented that the patient was admitted from the emergency room for having intractable severe lower back pain. The patient was unable to get up to go to the bathroom and unable to move her legs. Because of the severity of the pain, the patient was advised to be admitted. The patient was experiencing severe lower back pain. Pain was severe that she was unable to move from her bed to go to the bathroom. Diagnosis was intractable lower back pain. The patient was admitted for pain management. Magnetic resonance scans of the lumbar spine report dated June 6, 2014 demonstrated that at L3-4, there is 2 mm broad-based bulging of the annulus fibrosis into the spinal canal. At L4-5, there is 4 mm protrusion of the disc into the left central spinal canal extending to the left lateral recess. There is mild narrowing of the intervertebral space and decreased T2 signal of nucleus pulposus. At L5-S1, the intervertebral disc appears normal, and there is no evidence of spinal canal or neural foraminal stenosis. Four millimeter protrusion of the L4-5 intervertebral disc into the left central spinal canal and lateral recess was noted. The hospital discharge summary from the date of admission June 5, 2014 to

the date of discharge June 10, 2014 documented that the patient was unable to get up and even to go to the bathroom. With minimal movement, she was experiencing severe muscle spasm in the entire spine and lower extremities. The patient was unable to get up to go to the bathroom. The patient was unable to get up. She was having severe muscle spasms. Intravenous Dilaudid and Morphine was administered from June 5 through June 9, 2014. The hospital records document that the patient could not manage basic activities of daily living ADLs. Parenteral narcotics were administered. Per ODG, the hospital records provide support for the hospitalization from 06-05-2014 through 06-10-2014. Therefore the 6/5/14-6/10/14 hospital stay is supported. Therefore, the request for Retrospective inpatient length of stay times 5 days DOS 06/05/2014-06/10/2014 is medically necessary.