

<b>Case Number:</b>	CM15-0105696		
<b>Date Assigned:</b>	06/10/2015	<b>Date of Injury:</b>	12/22/1995
<b>Decision Date:</b>	07/17/2015	<b>UR Denial Date:</b>	05/08/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/02/2015

### 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: New York

Certification(s)/Specialty: Internal Medicine

### 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 58-year-old male, with a reported date of injury of 12/22/1995. The diagnoses include severe sepsis, septic shock, T1 paraplegia, neurogenic bowel and bladder, spasticity, history of head trauma, history of adjustment disorder secondary to disability, episodes of autonomic dysreflexia, and cervical syrinx. Treatments to date have included oral medications, an open tracheostomy, an electroencephalogram on 03/30/2015 and 04/06/2015, sigmoidoscopy with biopsy on 04/08/2015, and a computerized tomography (CT) scan of the abdomen to rule out abscess. The comprehensive neuropsychological evaluation dated 03/24/2015 indicates that the injured worker was referred to assess his current level of cognitive functioning to provide recommendations for treatment. The injured worker complained of headaches, dizziness, blurred vision, middle insomnia, increased appetite, decreased energy, loss of libido, spasticity, persistent sadness, anxiety, memory difficulties, attention problems, word finding difficulties, and recurrent thoughts about the accident. The injured worker's mental status and behavioral observations include a depressed mood with flat affect; improved mood during assessment; clear thought process; good judgment and insight; and good attention and concentration throughout the evaluation. The medical report dated 03/12/2015 indicates that the subjective findings include "weak". The objective findings include alert, fatigued, cooperative, no distress, clear lungs, normal heart exam, normal abdominal exam, and paraplegia. The emergency room report dated 03/11/2015 indicates that the injured worker's chief complaints were difficulty breathing and low blood pressure. The treating physician requested fifty-eight (58) inpatient hospital stay days (date of service: 03/11/2015-05/05/2015).

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Inpatient hospital stay, qty 58 (DOS: 3/11/15 to 5/7/15): 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-TWC), ODG Treatment, Integrated Treatment/Disability Duration Guidelines - Pulmonary (Acute & Chronic).

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines: Integrated Treatment/Disability Duration- Guidelines Pulmonary (Acute and Chronic).

**Decision rationale:** The review indicates the injured worker is a 58-year-old male, with a reported date of injury of 12/22/1995. The diagnoses include severe sepsis, septic shock, T1 paraplegia, neurogenic bowel and bladder, spasticity, history of head trauma, history of adjustment disorder secondary to disability, episodes of autonomic dysreflexia, and cervical syrinx. He was hospitalized with sepsis secondary to pyelonephritis on 3/12/15 and developed sepsis and cardiac arrest. He was in critical condition and required ICU level of care services 3/12-4/22/15. He also has ESRD on dialysis, decubit, MRSA, seizures and required mechanical ventilation and BiPAP during the night. His condition deteriorated and he was not considered an optimal candidate for transfer to a long-term acute care hospital. As of 5/5/2015, his status was changed to hospice level of care. For the dates of services 5/5-5/7/15, he did not require inpatient level of care services. Per ODG guidelines, in-hospital level of care services are covered for respiratory failure. In this case as of 5/5/15, the claimant was at hospice level of care and no longer required inpatient level of care services. Medical necessity for the inpatient hospital services 3/11-5/7/15 were not established. The inpatient hospital services (58 days total) were not medically necessary.