

<b>Case Number:</b>	CM15-0029173		
<b>Date Assigned:</b>	02/23/2015	<b>Date of Injury:</b>	11/01/2002
<b>Decision Date:</b>	04/22/2015	<b>UR Denial Date:</b>	02/10/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/17/2015

### 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: Oregon, California  
 Certification(s)/Specialty: Neurological Surgery

### 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 56-year-old male who reported an injury on 11/01/2002. The mechanism of injury was not specifically stated. The current diagnoses include chronic low back pain with right leg pain, significant multiple comorbidities, severe paresthesia in the right lower extremity and chronic pain. The injured worker presented on 01/16/2015 for a follow-up evaluation regarding chronic low back pain. It was noted that the injured worker was not interested in injections. The injured worker reported low back pain with radiating symptoms including numbness and weakness in the right lower extremity. The current medication regimen includes gabapentin and tramadol. Upon examination there was difficulty performing heel and toe walking on the right side, tenderness at the L5-S1 region, 45 degree flexion, 10 degrees extension, 25 degree lateral bending, positive straight leg raise on the right, 4+/5 motor weakness and diminished sensation in the bilateral feet. Recommendations at that time included a posterior spinal fusion and instrumentation from L3-S1. There was no Request for Authorization form submitted for review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Five day inpatient stay related to spinal surgery:** 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), Hospital Length of Stay Section.

**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 Chapter, Hospital Length of Stay.

**Decision rationale:** The Official Disability Guidelines recommend a median length of stay following a lumbar fusion to include 3 days. In this case, the injured worker's surgical procedure has not been authorized. Additionally, the request for a 5-day inpatient stay would exceed guideline recommendations. There were no exceptional factors noted. Given the above, the request is not medically appropriate.