

Case Number:	CM15-0086209		
Date Assigned:	05/08/2015	Date of Injury:	09/27/2013
Decision Date:	06/09/2015	UR Denial Date:	04/10/2015
Priority:	Standard	Application Received:	05/05/2015

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: Illinois, California, Texas
 Certification(s)/Specialty: Orthopedic 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 33-year-old male who sustained an industrial injury on 9/27/13. Injury occurred when he was unloading a table from a trailer and experienced a pop with onset of severe back pain. Past medical history was positive for a history of smoking, body mass index above 30, and gastric reflux. The 1/16/14 lumbar spine MRI demonstrated an L5/S1 disc bulge with moderate bilateral lateral recess stenosis and abutment of both traversing S1 nerve roots. The 4/6/15 treating physician report cited severe low back pain and left leg pain with tingling in the dorsal aspect of the left foot with frequent giving out of the left leg. He had completed 18 months of conservative treatment. There was MRI evidence of severe left L5/S1 stenosis. He underwent a left L5/S1 transforaminal epidural steroid injection on 3/26/15 with severe weeks of significant temporary pain relief. The diagnosis was left L5/S1 radiculitis secondary to L5/S1 degenerative spondylosis with severe foraminal stenosis. The treatment plan recommended left L5/S1 laminectomy and facetectomy with decompression of the left L5 nerve root. The 4/10/15 utilization review documented that the request for posterior lumbar laminectomy and facetectomy at left L5/S1 had been certified. An associated request for 2 day inpatient stay was modified to 1 day consistent with the Official Disability Guidelines for an uncomplicated lumbar decompression.

IMR ISSUES, DECISIONS AND RATIONALES

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

2 day Inpatient Hospital Stay: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disabilities Guidelines.

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: Hospital length of stay (LOS).

Decision rationale: The California MTUS does not provide hospital length of stay recommendations. The Official Disability Guidelines recommend the median length of stay (LOS) based on type of surgery, or best practice target LOS for cases with no complications. The recommended median length of stay of lumbar laminectomy is 2 days and best practice target is one day. The request for a 2-day inpatient stay following lumbar laminectomy is consistent with guidelines in this individual with some existing co-morbidities and medical necessity for close monitoring. Therefore, this request is medically necessary.