

Case Number:	CM14-0115168		
Date Assigned:	09/24/2014	Date of Injury:	10/29/1990
Decision Date:	12/31/2014	UR Denial Date:	07/16/2014
Priority:	Standard	Application Received:	07/23/2014

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 Occupational 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 a 73-year-old male who has submitted a claim for delirium, cerebrovascular accident on 3/2014, and hypertension, back pain, history of alcoholism, gastrointestinal bleed, and paroxysmal atrial fibrillation associated with an industrial injury date of 10/29/1990. Medical records from 2014 were reviewed. The patient was admitted on 3/21/2014 when he had a mechanical fall and was diagnosed with acute T1 compression fracture. He likewise had an episode of atrial fibrillation with rapid ventricular rate and hypotension. He was initially on Xarelto then shifted into Lovenox. He developed alcohol withdrawal with delirium tremens for which he was transferred to intensive care unit. The patient was heavily sedated and not following commands. He grimaced very little to painful status. Cardiovascular exam showed a systolic murmur and irregular S1 and S2 sounds. His pupils were reactive to light and equal. Lower extremity reflexes were brisk. He was discharged improved and stable until re-admission on 4/29/2014 due to low blood count with orthostatic hypotension. He likewise had an occult bleed. Both esophagogastroduodenoscopy and colonoscopy were unremarkable. The patient was discharged on 5/8/2014. The treatment to date has included Ativan, Xarelto, Lovenox, Lorazepam, Diazepam, Albuterol inhalation, Lipitor, Docusate, Midodrine, Nicotine patch, Protonix, Seroquel, Flomax, and Florinef. The utilization review from 7/16/2014 denied the request for inpatient admission and stay, DOA 07/03/2014 because of limited report of any new injuries, flare-up, or exacerbation of symptoms to support the requested inpatient stay.

IMR ISSUES, DECISIONS AND RATIONALES

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

Inpatient admission and stay, DOA 07/03/2014: 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 Other Medical Treatment Guideline or Medical Evidence: InterQual, Inpatient Stay

Decision rationale: The CA MTUS does not specifically address this topic. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers Compensation, the InterQual was used instead. InterQual notes that inpatient length of stay is based on need for: post-critical care monitoring, post-weaning monitoring, procedures requiring inpatient hospitalization, and nursing interventions at least every 4 to 8 hours. In this case, the patient was admitted on 3/21/2014 when he had a mechanical fall and was diagnosed with acute T1 compression fracture. He likewise had an episode of atrial fibrillation with rapid ventricular rate and hypotension. He was initially on Xarelto then shifted into Lovenox. He developed alcohol withdrawal with delirium tremens for which he was transferred to intensive care unit. The patient was heavily sedated and not following commands. He grimaced very little to painful status. Cardiovascular exam showed a systolic murmur and irregular S1 and S2 sounds. His pupils were reactive to light and equal. Lower extremity reflexes were brisk. He was discharged improved and stable until re-admission on 4/29/2014 due to low blood count with orthostatic hypotension. He likewise had an occult bleed. Both esophagogastroduodenoscopy and colonoscopy were unremarkable. The patient was discharged on 5/8/2014. However, the present request as submitted is for inpatient hospital stay on 7/3/2014. The most recent progress report submitted for review is dated May 2014. The medical necessity cannot be established due to insufficient information. Therefore, the request for inpatient admission and stay, DOA 07/03/2014 is not medically necessary.