

Case Number:	CM15-0121904		
Date Assigned:	06/25/2015	Date of Injury:	10/06/2009
Decision Date:	06/26/2015	UR Denial Date:	06/10/2015
Priority:	Expedited	Application Received:	06/24/2015

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: Anesthesiology

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This is a 30 year-old male who has reported low back pain after an assault on 10/6/09. His diagnoses have included radiculitis, spondylosis, anxiety, and chronic pain. He has been treated with chronic Oxycontin, Percocet, and Xanax. On 6/8/15 the injured worker was admitted for inpatient care to treat low back pain. While in the Emergency Department, he was reported to have had an acute episode of back pain 23 hours prior during which he fell to the ground. He reported difficulty ambulating. He was morbidly obese. In the Emergency Department he was reported to be in "no distress". Range of motion of the spine was "normal". There was bilateral leg weakness, decreased reflexes, diminished rectal tone, hypesthesia of the lower extremities, and saddle anesthesia. He was thought to have possible cauda equina syndrome. Tests ordered in the Emergency Department included MRIs and blood tests. 8 mg of parenteral Dilaudid and 200 mcg fentanyl did not relieve the pain. A neurosurgeon did not find evidence of cauda equina syndrome. The MRI showed only mild spondylosis. He was stated to be unable to ambulate. He was then admitted for inpatient care. The inpatient care included specialty consultations, further imaging, physical therapy, and IV medications (ondansetron, benzodiazepines, opioids). He was discharged on 6/11/15. The admission medication list included alprazolam, Percocet, Oxycontin. On 6/10/15 Utilization Review non-certified an inpatient admission, noting the ongoing back pain and lack of specific criteria to justify inpatient treatment. The available records did not provide further information about the Utilization Review decision.

IMR ISSUES, DECISIONS AND RATIONALES

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

Inpatient Admission: 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 chapter, Hospitalization.

Decision rationale: The medical necessity for inpatient treatment of back pain is not addressed in the MTUS. The Official Disability Guidelines, per the citation, above state that "The primary valid reason for hospitalizing these patients is that they cannot manage basic ADLs at home. Admission for the purpose of bed rest or traction alone is not acceptable. The need for parenteral narcotics is a valid admission criteria. A patient should not be admitted to a hospital that does not have the capacity to assess ADLs, develop a treatment plan, and provide physical therapy within the first 24 hours." This injured worker was admitted for treatment of pain and pain-related functional impairment, not for any physiological deficits, as he was cleared neurologically prior to admission. He was not adequately responsive to large quantities of parenteral opioids in the Emergency Department and was reportedly unable to ambulate at all. According to the Official Disability Guidelines criteria, this injured worker was eligible for inpatient care because he required parenteral narcotics and was unable to manage basic ADLs. The actual care delivered was consistent with the guideline recommendations, including acute physical therapy, a comprehensive treatment plan, and parenteral medications. This inpatient admission was therefore medically necessary.