

Case Number:	CM15-0126686		
Date Assigned:	07/13/2015	Date of Injury:	08/28/2001
Decision Date:	08/17/2015	UR Denial Date:	06/24/2015
Priority:	Standard	Application Received:	06/30/2015

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: California, North Carolina
 Certification(s)/Specialty: Family Practice

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 (IW) is a 49-year-old female who sustained an industrial injury on 08/28/2001. Diagnoses include displacement of lumbar intervertebral disc without myelopathy; spinal stenosis of lumbar region; sciatica; and acquired spondylolisthesis. Treatment to date has included medication, laminectomy and fusion, physical therapy and epidural steroid injection. Electrodiagnostic testing of the bilateral lower extremities on 12/6/14 found evidence of right tarsal tunnel syndrome. MRI of the lumbar spine on 12/4/14 showed multilevel disc desiccation; evidence of previous laminotomy and fixation; and impingement of the exiting L2 nerve. CT myelogram on 5/19/15 showed postoperative changes at L4-S1 with intact hardware; no evidence of high-grade central stenosis; disc and facet disease resulting in mild foraminal stenosis at L2-3 and mild to moderate suspected at L3-4. According to the progress notes dated 5/29/15, the IW reported increasing lower back pain radiating down both legs, with new symptoms of clicking and popping in the back and the legs giving out occasionally. On examination, there was increased pain with range of motion, decreased sensation in the left L4-S1 distribution and positive straight leg raise in the right lower extremity. Lumbar spine x-rays showed retrolisthesis of L3 on L4 with significant flexion and extension instability, possibly measuring 9mm off alignment or listhesis. Due to the instability of the lumbar spine, the provider gave the IW the option of surgical intervention, which was accepted. A request was made for length of stay five days in relation to recommended laminectomy and spinal fusion.

IMR ISSUES, DECISIONS AND RATIONALES

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

Length of Stay - 5: 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), Low Back Chapter, Hospital length of stay (LOS).

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.

Decision rationale: CA MTUS does not address length of stay in hospital following spinal surgery. The request is for 5 days in this case for laminectomy and spinal fusion. ODG states that for laminectomy, the median is 2 days with the mean of 3.5 days. For lumbar fusion, the median is 3 days, with best practices guidelines also recommending 3 days. In this case, the lumbar laminectomy with posterior spinal fusion has a mean of 3.9 days hospitalization. Therefore the request for 5 days exceeds the guidelines and is not medically necessary.