MEDICAL EVALUATORS
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DATE OF REVIEW: **July 10, 2018**

IRO CASE #: **XXXX**

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
1 In Patient Stay from XXXX-XXXX (XX days) due to hemorrhage (deep wound on the lower back due to liquid nitrogen canister explosion)

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION
This case was reviewed by a physician who holds a board certification in General Surgery who is currently licensed and practicing in the State of Texas.

REVIEW OUTCOME
Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

☒ **Upheld**

EMPLOYEE CLINICAL HISTORY [SUMMARY]:
The claimant is a XX who was injured on 05/24/2018 while sitting in front of a XX, the container exploded causing a laceration in the lower lumbar region. According to the admission notes dated XXXX, it was documented the claimant was admitted due to a hemorrhage with concerns of "morbidity or mortality in the short term" and the expected length of stay was "at least XX midnights". The history and physical notes by XXX, MD dated XXXX documented "deep wound in XX lower back with active bleeding, lacerations on left buttock and lower back. The objective findings included Glasgow Coma Scale (GCS) of 15/15. Physical exam of the head, neck, chest, abdomen, musculoskeletal was within normal limits. Inspection of the wound noted "lower back skin avulsion and 3x4 cm wound, deep." The claimant had a documented OT diagnosis of "Impaired BADL (Basics Activities of Daily Living) independence. Impaired IADL (Instrumental Activities of Daily Living) independence. Weakness. Activity intolerance. Impaired self-care mobility, Reduced joint ROM and Pain." A neurological consultation revealed that the claimant had "No neurological deficits, No involvement of spine on imaging, denies neck pain." The laboratory studies were within normal limits. The vital signs were stable. On XXXX, the neurological exam showed within normal limits bilaterally. Balance sitting and standing was static, good, dynamic and good. Range of motion of the bilateral lower extremities was within normal limits. Strength was 5/5 (normal) throughout the bilateral lower extremities. The claimant received occupational and physical therapy during the hospital stay. The therapy progress notes indicate that the claimant was tolerating therapy sessions and was able to ambulate using RW (rolling walker) with SBA (stand by assist).

Prior UR dated XXXX denied the request for coverage of 1 In Patient Stay from XXXX-XXXX (XX days) due to hemorrhage (deep wound on the lower back due to XXX) based

on the ODG Treatment Integrated Treatment/Disability Duration Guidelines for Low Back-Lumbar and Thoracic (Acute and Chronic) and according to the UR the discharge summary indicated that "the only issue for keeping this person in the hospital is there was a lack of transportation to send this person home."

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION.

The claimant is a XX who was injured on XXXX while sitting in front of a XX, the XX causing a laceration in the lower lumbar region. The claimant was admitted at inpatient level of care from XXXX-XXXX.

After review of the records submitted, there is insufficient evidence that the hospitalization stay from XXXX-XXXX was medically necessary. This claimant had deep laceration injury to the lower back. However, there was no documentation of neurological deficits and motor and sensory testing was normal. The laboratory studies were within normal limits. The vital signs were stable. The claimant was able to ambulate shortly after the injury. There is no evidence of major infection or need for parenteral antibiotics. It appears that this claimant could have been treated at a lower level of care and does not meet the medically necessity criteria for inpatient level of care for 8 days.

Therefore, based on the ODG criteria as well as the clinical documentation stated above, the request of 1 In Patient Stay from XXXX-XXXX (XX days) due to hemorrhage (deep wound on the lower back due XX) is not medically necessary and appropriate.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES – Online Version
Low Back - Lumbar and Thoracic (Acute and Chronic) - (updated 05/04/18)

Hospitalization

Not recommended for low back pain in the absence of major trauma (i.e., acute spinal fracture, spinal cord injury, or nerve root injury), acute or progressive neurologic deficit, or the patient's inability to manage basic ADLs at home and alternative placement in a Skilled Nursing Facility is not available or appropriate. These recommendations are based on medical practice and are consistent with other evidence-based guidelines. (Washington, 2002) (ICSI, 2004)

Criteria for Hospital Admissions:

I. Acute Major Back Trauma is Suspected:

- Back injury occurred within the past 7 days;
- Major trauma was sustained (e.g., fall from a height or back crushed by heavy object);
- Examining physician documents or suspects acute spinal fracture, spinal cord injury, or nerve root injury.
- *Hospital Admission Criteria*: May be individualized.

II. Acute Major Back Trauma Not Suspected; Patient Has Neurologic Findings Suspected to be Acute or Progressive:

- No history of recent major injury;
- Patient complains of symptoms suggesting acute or progressive neurologic deficit [typically these include: (1) progressive weakness or numbness in one leg (and occasionally both legs), or (2) loss of control of bowel or bladder function, or (3) progressive numbness in the perineal region];
- The examining physician indicates that the patient has (or probably has) an acute or progressive neurologic deficit.
- *Hospital Admission Criteria*: If a patient has a new or progressive neurologic deficit, he/XX may be hospitalized in order to facilitate surgical decision-making, to provide close observation of further progression, or to help the patient compensate for neurological deficits (e.g., to determine whether the patient needs to learn intermittent catheterization). If a patient does NOT have a new or progressive neurologic deficit, the only valid reason for hospitalization is that he/XX cannot manage basic ADLs at home. Duration of hospitalization should be brief. The great majority of these patients who are admitted to a hospital can be discharged in 1 to 3 days (if spine surgery is not performed). Prolonged bed rest usually does more harm than good in a patient with low back pain. Admission for the purpose of bed rest is not acceptable.

III. Acute Major Back Trauma Not Suspected; Patient Has Back Pain without Evidence of Acute or Progressive Neurologic Findings:

- No history of recent major trauma;
- Patient complains of back pain with or without symptoms in the legs (occasionally patients will complain mainly of symptoms in the legs but the evaluating physician concludes that symptoms are not caused by lumbar radiculopathy);
- No evidence of acute or progressive neurologic deficit.
- *Hospital Admission Criteria*: The primary valid reason for hospitalizing these patients is that they cannot manage basic ADLs at home. For example, the patient lives alone and is unable to get to the bathroom. If a patient is admitted through the emergency department, the decision to admit should be made with the concurrence of the attending physician, unless the attending physician cannot be reached. Duration of hospitalization should be brief. The great majority of these patients who are admitted to a hospital can be discharged in less than 24 hours. Admission for the purpose of bed rest or traction alone is not acceptable. The need for parenteral narcotics is a valid admission criterion. 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.

ODG hospital length of stay (LOS) guidelines:
Discectomy (*ICD 80.51 - Excision of intervertebral disc*)

For prospective management of cases, median is a better choice that mean (or average) because it represents the mid-point, at which half of the cases are less, and half are more. For retrospective benchmarking of a series of cases, mean may be a better choice unless making comparisons to other medians (so as to compare like to like). Length of stay is the number of nights the patient remained in the hospital for that stay, and a patient admitted and discharged on the same day would have a length of stay of zero. The total number of days is typically measured in multiples of a 24-hour day that a patient

occupies a hospital bed, so a 23-hour admission would have a length of stay of zero. (HCUP, 2011) Of recent lumbar discectomy cases, 62% underwent an inpatient hospital stay after surgery, whereas 38% had outpatient surgery, and outpatients had lower overall complication rates than those treated as inpatients. (Pugely, 2013)

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NOTICE ABOUT CERTAIN INFORMATION LAWS AND PRACTICES With few exceptions, you are entitled to be informed about the information that the Texas Department of Insurance (TDI) collects about you. Under sections 552.021 and 552.023 of the Texas Government Code, you have a right to review or receive copies of information about yourself, including private information. However, TDI may withhold information for reasons other than to protect your right to privacy. Under section 559.004 of the Texas Government Code, you are entitled to request that TDI correct information that TDI has about you that is incorrect. For more information about the procedure and costs for obtaining information from TDI or about the procedure for correcting information kept by TDI, please contact the Agency Counsel Section of TDI's General Counsel Division at (512) 676-6551 or visit the Corrections Procedure section of TDI's website at www.tdi.texas.gov.