

Case Number:	CM13-0047627		
Date Assigned:	12/27/2013	Date of Injury:	04/12/2010
Decision Date:	05/23/2014	UR Denial Date:	10/04/2013
Priority:	Standard	Application Received:	11/04/2013

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 Orthopedic Surgery 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 injured worker is a 65-year-old female who reported an injury on 04/12/2010, the mechanism of injury reported was a fall. The clinical note dated 09/20/2013 noted that the injured worker presented with complaints of pain to bilateral knees. Physical examination noted pain with range of motion to right knee. The diagnoses included right knee injury, hypertension, and obesity. The surgical history was note as 09/20/2013 for a right total knee. The injured worker was discharged home on 09/24/2013. The injured worker has a history of physical therapy prior to the surgery for her knee. Medication list and diagnostic studies were provided in the medical records for review. The physician did not provide a rationale for the requested treatment. The clinical note dated 11/20/2013 that the injured worker was status post a right total knee. The injured worker was to discharge home with therapy. No levels of pain or range of motion was noted in the medical records for review. The requested treatment is for continued three week stay at nursing care center. The DWC form RFA was not included in the documentation for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

THREE (3) WEEKS CONTINUED STAY AT NURSING CARE CENTER: 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), Knee and Leg Procedures.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG) KNEE & LEG (ACUTE & CHRONIC), SKILLED NURSING FACILITY (SNF) CARE

Decision rationale: The Expert Reviewer's decision rationale: The request for the 3 weeks continued stay at the nursing care center is non-certified. The Official Disability Guidelines recommend it is necessary after hospitalization for a patient to go to skilled nursing or skilled rehabilitation facility for services, or both on a 24 hour basis, if they reach and meet the criteria set forth in the Official Disability Guidelines. The criteria for skilled nursing care is the patient was hospitalized for at least 3 days from major multiple trauma, or major surgery, such as spinal surgery, total hip or knee replacement or was admitted to a Skilled Nursing Facility within 30 days of a hospital discharge. The physician must certify that a patient requires a skilled nursing facility for care of major treatment or multiple trauma, postoperative significant functional limitations or associated significant medical comorbidities with new functional limitations that prevent management with lower levels of care and that the skilled nursing facility is a Medicare certified facility. The documentation provided for review did not have any current functional deficits, pain levels, medications, any current therapeutic sessions that the injured worker received. Documentation was not provided regarding the injured worker's therapy, medications received, diagnostic testing. There was no documentation provided for any significant new functional limitations on the injured worker such as ambulation, performing activities of daily living like self care or eating or toileting. Therefore, the request for the 3 weeks continued stay at the nursing care center does not meet the guidelines set forth by the Official Disability Guidelines. Therefore, the request for three (3) weeks continued stay at nursing care center is not medically necessary.