

Case Number:	CM13-0055263		
Date Assigned:	12/30/2013	Date of Injury:	04/10/2000
Decision Date:	03/26/2014	UR Denial Date:	11/07/2013
Priority:	Standard	Application Received:	11/20/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Family Practice, and is licensed to practice in Texas. 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 physician 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 57 year old female who reported injury on 02/19/1999. The mechanism of injury was noted to be the patient lost her footing as she stepped off the wing of an airplane onto a gig (a ladder-type stand). The patient fell approximately 7 feet to a concrete floor. The patient subsequently underwent a bilateral knee procedure in 2000. The patient underwent emergency L4-5 nerve root and cauda equina decompression on 05/17/2013. The patient subsequently was transferred to [REDACTED] and subsequently to [REDACTED]. The patient was noted to be in a wheelchair for over 6 years and had continued to be in a wheelchair although the patient was noted to be capable of standing up, taking steps, and walking with a walker. The patient had an indwelling catheter and had been on a bowel regimen to follow daily. The patient complained of pain in the left lower posterior iliac crest region that was exquisitely tender upon palpation. The patient was extremely weak in the lower limbs prior to spinal surgery, but subsequently improved to the point she could walk 70 feet with the use of walker on a daily basis. Neurologically, the patient had strength of 4+/5 to 5-/5 in the hip flexors, knee extensors and knee flexors. Strength was noted to be 4-/5. The foot dorsiflexion on the left side was found to be weak at 2+/5 and on the right was 3+/5 to 4-/5. The straight leg raise was 70 to 80 degrees in the sitting position. The patient had hypalgesia of L5-S5 bilaterally, which at some areas were denser than others without a clear dermatomal pattern. Palpation to the low back revealed no discomfort at the surgical site. The lower posterior iliac crest on the left side paramedian to the left was exquisitely tender upon deep palpation, but no abnormalities were noted on the skin surface. The patient's diagnoses were noted to be cauda equina syndrome, neurogenic bowel/neurogenic bladder, musculoskeletal and neuropathic pain, adjustment disorder presenting with depressed mood secondary to disability and history of bilateral knee procedure. The patient was noted to continue working with physical therapy and occupational therapy with the goal of

being independent in both home and community. The request was made for a continued stay for skilled nursing facility for nursing and rehabilitative services for 1 to 2 weeks

IMR ISSUES, DECISIONS AND RATIONALES

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

Continued stay for skilled nursing facility and rehabilitative therapy services 1-2 weeks:

Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines- online version- Skilled nursing Facility Care.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back Chapter, skilled nursing facility care.

Decision rationale: The Official Disability Guidelines recommend skilled nursing facility care if necessary after hospitalization when patients require skilled nursing or skilled rehabilitation services or both on a 24-hour basis. Clinical documentation submitted for review failed to indicate the patient had a requirement of skilled nursing or skilled rehabilitation services for 24 hours, although the patient had an indwelling catheter. There was a lack of documented requested dates of service per the submitted request. As such, there was an inability to indicate if, for the dates of requested service, the patient was eligible for a skilled nursing facility. Given the above and the lack of documentation, the request for continued stay for skilled nursing facility for nursing and rehabilitative therapy services for 1 to 2 weeks was not medically necessary and appropriate.