

Case Number:	CM14-0015559		
Date Assigned:	02/28/2014	Date of Injury:	12/28/2005
Decision Date:	07/07/2014	UR Denial Date:	01/23/2014
Priority:	Standard	Application Received:	02/06/2014

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 Physical Medicine & Rehabilitation and Pain Medicine and is licensed to practice in Texas and Oklahoma. 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 49-year-old female with a reported date of injury on 12/28/2005. The injured worker underwent an L4-5 decompressive laminectomy on 01/16/2014. Postoperatively, the injured worker complained of left leg pain, but was improved and motor strength remained intact. Postoperatively, the injured worker was awake and alert, able to walk partway down the hallway without feeling "too shaky" from weight bearing. Incision was healthy and dry. Within the clinical documentation provided for review, the physician also indicated that the injured worker had normal bowel and bladder function, lungs were clear to auscultation, and she was assessed as stable for discharge. According to the clinical note dated 01/22/2014, the injured worker was to be discharged on 01/20/2014. The physician indicated that after speaking with the husband, the injured worker felt she should be discharged to a skilled nursing facility. On 01/22/2014, the injured worker was discharged to home, with 24 hour supervision provided by family. According to the clinical note dated 01/20/2014, the injured worker indicated her pain was 5/10 with medication. According to the occupational therapy mobility assessment, the injured worker was able to roll to right side, right roll to supine, supine to sit, and scooting sitting with standby assistance. In addition, the injured worker was able to transfer sit to stand, stand to sit, and bedside commode with minimal assistance. The occupational therapy note indicated the need for the injured worker to be discharged with 24-hour supervision. The diagnosis included spinal stenosis with spondylolisthesis. The medication regimen was not provided within the clinical information available for review. The request for authorization to transfer to a skilled nursing facility for inpatient rehab was submitted on 02/06/2014. The rationale for the request was not provided within the documentation available for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

TRANSFER TO A SKILLED NURSING FACILITY FOR INPATIENT REHAB: Upheld

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) Knee, Skilled Nursing Facility (SNF) Care.

Decision rationale: According to the Official Disability Guidelines, skilled nursing care is recommended if necessary after hospitalization when the patient requires skilled nursing or skilled rehab services, or both, on a 24-hour basis. Criteria for skilled nursing care would include the injured worker was hospitalized for at least 3 days for major or multiple trauma or surgery, a physician certifies that the patient needs SNF care for treatment, there are no caregivers at home, or the patient cannot manage at home. In order to be deemed skilled, the service must be so inherently complex that it can be safely and effectively performed only by, or under the supervision of, professional or technical personnel. The clinical information provided for review lacks documentation of need for skilled care. It is noted within the clinical documentation that the injured worker has family that will be able to supervise her at home. In addition, the occupational therapy physical exams reveal that the injured worker is able to stand and transfer, with only standby assistance. In addition, the physician does not certify that the injured worker requires skilled nursing care. Therefore, the request to transfer to a skilled nursing facility for inpatient rehab is not medically necessary.