

Case Number:	CM14-0032852		
Date Assigned:	06/20/2014	Date of Injury:	04/01/2003
Decision Date:	08/05/2014	UR Denial Date:	02/28/2014
Priority:	Standard	Application Received:	03/14/2014

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 Anesthesiology, has a subspecialty in Pain Management 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:

According to the records made available for review, this is a 65-year-old female with a 4/1/03 date of injury, and status post right-sided laminotomy, status post revision decompression and posterior spinal fusion L4-S1 2/05, status post L2-3 and L3-4 transforaminal lumbar interbody fusion (TLIF) with hardware removal L4-S1 4/11/13, and status post lumbar hardware removal with irrigation and debridement 12/24/13. At the time (2/28/14) of request for authorization for additional skilled nursing home for 90 days, there is documentation of subjective (usual pain had decreased slightly) and objective (incision healing very well, no signs of infection) findings, current diagnoses (status post right-sided laminotomy, status post revision decompression and posterior spinal fusion L4-S1 2/05, status post L2-3 and L3-4 TLIF with hardware removal L4-S1 4/11/13, and status post lumbar hardware removal with irrigation and debridement 12/24/13), and treatment to date (medications, home health care, and skilled nursing home). 2/5/14 medical report identified that the patient is in a skilled nursing home which should be continued as the patient is being monitored for anemia and continues to have difficulty with prolonged walking and activities of daily living. There is no documentation that the patient requires skilled nursing or skilled rehabilitation services, or both, on a daily basis or at least 5 days per week; that treatment is precluded in lower levels of care; and that the skilled nursing facility is a Medicare certified facility.

IMR ISSUES, DECISIONS AND RATIONALES

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

ADDITIONAL SKILLED NURSING HOME X 90: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES.

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, Knee, Skilled nursing facility (SNF) care.

Decision rationale: The CA MTUS does not address this issue. The ODG identifies documentation that the patient was hospitalized for at least three days for major or multiple trauma, or major surgery (e.g. spinal surgery, total hip or knee replacement) and was admitted to the SNF within 30 days of hospital discharge; a physician certifies that the patient needs SNF care for treatment of major or multiple trauma, post-operative significant functional limitations, or associated significant medical comorbidities with new functional limitations that preclude management with lower levels of care (e.g. COPD, heart disease, ventilatory support, spinal cord injury, significant head injury with cognitive deficit); the patient has a significant new functional limitation such as the inability to ambulate more than 50 feet, or perform activities of daily living (such as self care, or eating, or toileting); the patient requires skilled nursing or skilled rehabilitation services, or both, on a daily basis or at least 5 days per week (skilled nursing and skilled rehabilitation services are those which require the skills of technical or professional personnel such as nurses, physical therapists, and occupational or speech therapists. 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 patient must be able to benefit from, and participate with at least 3 hours per day of physical therapy, occupational therapy and / or speech therapy); treatment is precluded in lower levels of care (e.g. there are no caregivers at home, or the patient cannot manage at home, or the home environment is unsafe; and there are no outpatient management options); and that the skilled nursing facility is a Medicare certified facility, as criteria necessary to support the medical necessity of SNF care, as criteria necessary to support the medical necessity of SNF care. Within the medical information available for review, there is documentation of diagnoses of status post right-sided laminotomy, status post revision decompression and posterior spinal fusion L4-S1 2/05, status post L2-3 and L3-4 TLIF with hardware removal L4-S1 4/11/13, and status post lumbar hardware removal with irrigation and debridement 12/24/13. In addition, there is documentation that the patient was hospitalized major surgery (spinal surgery) and was admitted to the SNF within 30 days of hospital discharge and that the patient has a significant new functional limitation to perform activities of daily living. However, there is no documentation that the patient requires skilled nursing or skilled rehabilitation services, or both, on a daily basis or at least 5 days per week; that treatment is precluded in lower levels of care; and that the skilled nursing facility is a Medicare certified facility. Therefore, based on guidelines and a review of the evidence, the request for additional skilled nursing home for 90 days is not medically necessary.