MAXIMUS Federal Services

Case Number:	CM14-0027800		
Date Assigned:	07/23/2014	Date of Injury:	04/18/2013
Decision Date:	01/28/2015	UR Denial Date:	02/10/2014
Priority:	Standard	Application Received:	03/05/2014

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 Family Practice 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 39-year-old male who sustained an industrial injury 04/18/13 when he incurred a fall from tripping over a chair, landing on his back, which resulted in him having surgery 05/01/13, for disk fragments from his spine. He reported that he felt pain as soon as he got up, feeling a shooting pain down his left leg. He had footdrop following that procedure and then on 11/06/13, he had an epidural injection. On 01/22/14, he had surgical revision due to the multilevel lumbar spine pain with fusions. His medications included dexamethasone 6 mg, Valium 5 mg, Colace 100 mg, nicotine 20 mg, oxycodone ER 10 mg, Flexeril 10 mg, hydromorphone 1 mg, Zofran 4 mg, and Oxycodone IR 5 mg. Upon examination, he had decreased sensation on the left foot consistent with almost a pattern of a sock he was wearing. He had left foot drop, and decreased strength on the left. Diagnoses/impression were left leg pain with foot numbness and low back pain with lumbar fusion 01/22/14, for herniated nucleus pulposus (HNP) with a large free-floating disk fragment measuring larger than 15 cm and radiculitis; left foot drop; insomnia; urinary retention with Foley catheter; multiple tattoos; anemia; unsteady gait; and obesity. He was admitted to the hospital for acute rehab following a revision of a prior spinal surgery with the expectation his functional level would improve and he could return home. He did well after the Foley catheter was removed and he showed good progress. He was able to ambulate with a walker, his hospital course was uneventful, he was stable and ready for discharge home on 02/11/14. While in the hospital, he underwent a L4-L5-S1 posterior fusion/decompression. Lumbar spine MRI done 08/07/13, showed nerve root inflammation, arachnoiditis suggestion of L4-L5, deformity of the bilateral L3 through L5 nerve roots, massive effect on transiting right L5 nerve root. During his hospital stay, he seemed to experience some issues with pain control, as he was using considerable doses of Dilaudid through the PCA in addition to receiving breakthrough Dilaudid subcutaneous injections which

were helpful to help him move in and out of bed. Per the surgeon's progress notes, the Hemovac drainage decreased, the lumbar dressing was removed, and the staple line was intact. The Hemovac was removed without complications and a gauze dressing was applied on 01/24/14. On 01/28/14, a lumbar spine CT was performed which showed a L4 vertebral body fracture. His physicians discussed the complication of the lumbar fracture and did not expect any instability in the lumbar spine and ordered to continue physical therapy and for him to be out of bed as previously ordered.

IMR ISSUES, DECISIONS AND RATIONALES

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

Inpatient rehabilitation: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines physical medicine.

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 - Lumbar & Thoracic (Acute & Chronic), Lumbar fusion 01/22/14, for herniated nucleus pulposus (HNP) with a large free-floating disk fragment measuring larger than 15 cm and radiculitis.

Decision rationale: SNF admission is recommended if necessary after hospitalization when the patient requires skilled nursing or skilled rehabilitation services, or both, on a 24-hour basis. A Skilled Nursing Facility or SNF, has Registered Nurses who help provide 24-hour care to people who can no longer care for themselves due to physical, emotional, or mental conditions. A licensed physician supervises each patient's care and a nurse or other medical professional is almost always on the premises. This may include: an R.N. doing wound care and changing dressings after a major surgery, or administering and monitoring I.V. antibiotics for a severe infection; a physical therapist helping to correct strength and balance problems that have made it difficult for a patient to walk or get on and off the bed, toilet or furniture; a speech therapist helping a person regain the ability to communicate after a stroke or head injury; an occupational therapist helping a person relearn independent self-care in areas such as dressing, grooming and eating. The request is not reasonable as length of rehab request was not clarified and rationale is unclear as there is no documentation that patient requires skilled nursing or skilled rehabilitation services, or both, on a 24-hour basis. Therefore, this request is not medically necessary.