

Case Number:	CM15-0144751		
Date Assigned:	08/06/2015	Date of Injury:	05/23/2001
Decision Date:	09/09/2015	UR Denial Date:	07/02/2015
Priority:	Standard	Application Received:	07/27/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: California, Hawaii

Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 was a 73 year old female, who sustained an industrial injury, May 23, 2001. The injured worker previously received the following treatments radiofrequency ablation to the bilateral L3 and L4 medial branches, Celebrex Valium, Flexeril, L3-S1 fusion, lumbar CT scan and myelogram on April 7, 2015. The injured worker was diagnosed with L3-S1 reconstruction stabilization, most recent operative undertaking to include the L3-L4 level, adjacent segment pathology L2-L3 spondylosis, facet arthrosis, potential micro-instability with residual symptoms and retained neuro-stimulator for the bladder dysfunction. According to progress note of April 16, 2015, the injured worker's chief complaint was worsening pain in the lower back, gluteal region and lower extremity anterior thigh region. The injured worker rated the worst pain at 8 out of 10. The injured worker reported that the activities of daily living had decreased and continued to be dependent on mediation. The physical exam noted tenderness with palpation of the paralumbar musculature. The straight leg raises were positive. The facet loading sign was positive. There were sensory deficits in the L2-L3 dermatomal distribution bilaterally. The injured worker continued to sit in an asymmetric posture, using the upper arms to support the torso. The treatment plan included two weeks of acute rehabilitation of physical therapy and occupational therapy.

IMR ISSUES, DECISIONS AND RATIONALES

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

Acute Rehab, 2 weeks, (PT - physical therapy /OT - occupational therapy), in patient:
Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines: Low Back, Lumbar & Thoracic (Acute & Chronic) - Hospital length of stay (LOS).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Low Back (Acute & Chronic),: Hospital length of stay.

Decision rationale: According to the medical records provided, the patient has complaints of low back pain, as well as reduced ability to perform activities of daily living following posterior lumbar spine fusion on 6/24/15. The current request is for Acute Rehab, 2 weeks, (PT - physical therapy/OT occupational therapy), in-patient. The CA MTUS does not provide recommendations for acute in-patient rehabilitation in-patient. According to the Official Disability Guidelines (ODG), the median length of hospital stay based on type of procedure, is three days for lumbar fusion surgery. In this case, The IW was in the hospital until at least 7/1/2015. The inpatient PT note of 7/1/2015 stated that 1-2 more days of PT were needed before discharge home. There is no mention of a need to transfer the IW to an inpatient rehabilitation facility for 4 hours per day and 6 days per week of therapy. Review of the medical records provided indicate that additional days in a skilled nursing facility would be more appropriate. As such, the records do not establish medical necessity for the request.