

<b>Case Number:</b>	CM14-0180819		
<b>Date Assigned:</b>	11/05/2014	<b>Date of Injury:</b>	05/06/2000
<b>Decision Date:</b>	12/09/2014	<b>UR Denial Date:</b>	10/03/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/30/2014

### 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 American Board of Internal Medicine 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 (IW) is a 52-year-old woman with a work related injury dating back 14 years ago. The original date of injury was May 6, 2000. The mechanism of injury was not documented in the medical record. The IW has an extensive medical history including chronic low back pain. She was admitted to the hospital in February after a fall, which increased her back pain. She was discharged to [REDACTED] where she stayed approximately 3 weeks. According to the IW, she stopped all of her medications because she did not have any refills and she was in quite a bit of pain. She was unable to see primary care provider. She attempted to care for herself at home but was unable to do so without medications. Her foot was bothering her significantly and she was unable to ambulate so she presented to the ER again on April 6, 2014. Subjective complaints on April 6, 2014 included back pain, and left knee pain. Physical examination revealed no edema or calf tenderness. Normal pulses in all extremities. Left knee exam showed patella externally deviated, pain on the terminal flexion. Hip exam shows limited internal rotation. The lower back was diffusely tender in the paraspinal muscles. Axillae are negative bilaterally. Current medications include: Aspirin 81mg, Valium 5mg, Percocet 5/325mg, Colace 250mg, Glucotrol 10mg, Lantus 15 units daily, Lisinopril 10mg, Senokot at night, and Effexor 300mg. The IW had been discharged from an acute rehabilitation facility just 2 weeks prior. The IW had been treated primarily for rehabilitation issues related to her chronic pain, gait pathology, and therapy for self-care. On the day of acute admission, there was a case management note that stated that re-admission to the care facility had been arranged for that specific date. The treating ER physician supported the plan for readmit to acute rehabilitation. However, the notes also revealed that the IW had adamantly refused readmission to the rehab facility. During the acute admission, the IW had been treated for chronic pain syndrome, and secondary pathology of gait,

self-care and activities of daily living. The IW was ultimately discharged on April 16, 2014 back to [REDACTED].

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

#### **Retrospective Inpatient Stay (DOS 46-4/16/14): Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Skilled nursing facility (SNF) care

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation American Medical Association, Centers for Medicare and Medicaid <http://www.acmq.org/policies/policy8.pdf>

**Decision rationale:** Pursuant to the American Medical Association definition and the Centers for Medicare and Medicaid definition, the inpatient hospital stay was not medically necessary. The American Medical Association defined medically necessary as services or procedures that a prudent physician would provide for patient in order to prevent, diagnose or treat an illness, injury or disease or the associated symptoms in a manner that is in accordance with the generally accepted standard of medical practice; clinically appropriate in terms of frequency, type, extent, site and duration; and not for the intended or economic benefit of the health plan or purchaser for the convenience of the patient physician or other health-care provider. The Medicare definition states medical necessity from a Medicare perspective is defined under title 18 of the Social Security act section 1862 (a)(1)(a). The section states "no payment may be made under part A or part B for expenses incurred for items or services which are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member". In this case, the injured worker, a 52-year-old woman, presented to the hospital with a chief complaint of difficulty caring for herself at home with family with back pain, left knee pain and leg pain (page 310). The injured worker has an extensive past medical history with chronic low back pain from a work-related injury 14 years ago. All of her pain medications were recently discontinued. The injured worker states she tried to care for herself at home without any pain medicines but has been unable to do so. Her physical examination was unremarkable. Her labs were unremarkable. She was given a dose of Dilaudid in the emergency room. The impression stated "the patient is a 52-year-old female with chronic back pain and left knee and hip pain from osteoarthritis, presented to hospital with difficulty caring for herself at home secondary to increasing pain. She will be admitted to the hospital. There were several other comorbid conditions; however they were all stable at the time of admission. The last admission assessment dealt with social issues and it states "as noted earlier she will most likely need placement as she has been having difficulty caring for herself at home". The injured worker did not have any acute complaints that required acute inpatient services. There was a discharge planning note from the day of (page 325) by the discharge planner who states the patient adamantly refused to return to the facility for rehabilitation. The decision was then made by the hospitalist to admit the patient. The medical condition, safety and health of the injured worker would not have been significantly and directly threatened if care was provided in a less intensive setting. A less intensive setting might have been observation overnight within the hospital with subsequent transfer to a skilled

nursing facility or rehab facility the following day. The hospital stay was still not medically necessary. Although not explicitly enumerated, the hospital stay was more for the convenience of the injured worker and or physician but clearly the injured worker did not require acute inpatient services. Under the Medicare guidelines the services rendered to the injured worker were not reasonable and necessary for the diagnosis or treatment of an illness or injury. Consequently, the decision for retrospective inpatient stay (dates of service April 6, 2014 through April 16, 2014) is not medically necessary.