

<b>Case Number:</b>	CM13-0065175		
<b>Date Assigned:</b>	01/03/2014	<b>Date of Injury:</b>	05/18/2011
<b>Decision Date:</b>	04/14/2014	<b>UR Denial Date:</b>	12/09/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/12/2013

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Anesthesiology, has a subspecialty in Acupuncture & Pain 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 physician 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 patient is a 60-year-old male injured worker with date of injury 5/18/11. The patient is status post traumatic head injury, status post frontal parietal craniotomy with extraction of hematoma on 5/8/11 with residual subdural hematoma; status post right shoulder surgery on 10/24/13. The patient has a history of multiple facial fractures and right posterior fracture, dental and jaw trauma, and bilateral rib fracture. He was also diagnosed with right shoulder impingement and mild rotator cuff tear, supraspinatus tendon and subscapular degeneration, right biceps rupture; cervical spine sprain/strain with bilateral upper extremity radiculopathy and thoracolumbar sprain/strain; and thoracolumbar compression fracture. The patient was refractory to surgery, physical therapy, and medication management. The date of utilization review decision was 12/9/13.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**DAY TREATMENT PROGRAM EVALUATION FOR 10 DAY:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Chronic pain programs (functional restoration programs) Page(s): 30-31.

**Decision rationale:** With regard to functional restoration programs, the MTUS states "Recommended where there is access to programs with proven successful outcomes, for patients with conditions that put them at risk of delayed recovery. Patients should also be motivated to improve and return to work, and meet the patient selection criteria outlined below." "Outpatient pain rehabilitation programs may be considered medically necessary when all of the following criteria are met: (1) An adequate and thorough evaluation has been made, including baseline functional testing so follow-up with the same test can note functional improvement; (2) Previous methods of treating chronic pain have been unsuccessful and there is an absence of other options likely to result in significant clinical improvement; (3) The patient has a significant loss of ability to function independently resulting from the chronic pain; (4) The patient is not a candidate where surgery or other treatments would clearly be warranted (if a goal of treatment is to prevent or avoid controversial or optional surgery, a trial of 10 visits may be implemented to assess whether surgery may be avoided); (5) The patient exhibits motivation to change, and is willing to forgo secondary gains, including disability payments to effect this change; & (6) Negative predictors of success above have been addressed." The negative predictors of success include: "(1) a negative relationship with the employer/supervisor; (2) poor work adjustment and satisfaction; (3) a negative outlook about future employment; (4) high levels of psychosocial distress (higher pretreatment levels of depression, pain and disability); (5) involvement in financial disability disputes; (6) greater rates of smoking; (7) duration of pre-referral disability time; (8) prevalence of opioid use; and (9) pretreatment levels of pain." A review of the submitted medical records does not reveal rationale from the primary treating physician establishing the medical necessity of this request. Furthermore, the above stated criteria have not been met. The request is not medically necessary.

**TRANSPORTATION:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 9 Shoulder Complaints, Chapter 10 Elbow Disorders (Revised 2007), Chapter 11 Forearm, Wrist, and Hand Complaints, Chapter 12 Low Back Complaints, Chapter 13 Knee Complaints, Chapter 14 Ankle and Foot Complaints.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee & Leg, Transportation

**Decision rationale:** The MTUS is silent on the use of transportation services in the management of injuries or to and from procedures. As the request for the day treatment program was not medically necessary, this request is also not medically necessary. Per Official Disability Guidelines (ODG), transportation is "recommended for medically-necessary transportation to appointments in the same community for patients with disabilities preventing them from self-transport." The documentation does not detail the injured worker's disability that prevents him from self transport. As such, the request is not certified.

**INTERPRETER:** Overturned

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 9 Shoulder Complaints, Chapter 10 Elbow Disorders (Revised 2007), Chapter 11 Forearm, Wrist, and Hand Complaints, Chapter 12 Low Back Complaints, Chapter 13 Knee Complaints, Chapter 14 Ankle and Foot Complaints.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: <https://www.dir.ca.gov/dwc/Interpreter/InterpreterFAQs.html>

**Decision rationale:** The MTUS is silent on the use of interpreter services in the management of injuries. Per the Division of Worker's Compensation website, "interpreter services must be provided at a deposition, at an appeals board hearing, at a medical-legal examination, and at a medical treatment appointment." Thus, interpreter services are medically necessary.