

<b>Case Number:</b>	CM13-0066337		
<b>Date Assigned:</b>	01/03/2014	<b>Date of Injury:</b>	10/26/1997
<b>Decision Date:</b>	05/30/2014	<b>UR Denial Date:</b>	11/21/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/16/2013

### 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 Physical Medicine and Rehabilitation, 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 patient is a 75 year old male who was injured on 10/26/1977. The mechanism of injury is unknown. Prior treatment history has included certification for repeat Botox injections dated 11/21/2013 as well as psych re-exam certification for behavioral issues, Urological follow-up and Rheumatology consultation for osteoarthritis involving the ring finger of the left hand. Review of Medical Records dated 11/07/2013 with the following: The 11/01/2013 Medical Management Progress Report notes "Adult Day Health Care services provided at the Adult Day Health Care Center are those of nursing, personal care, social services, therapeutic activities related to occupational and physical therapy as well as meal service. These services had been provided previously. It kept his mind engaged in activities related to socialization and his body active with physical and occupational therapy exercises. There were stopped only because of medical conditions requiring interventions. These conditions have stabilized; in fact, the patient has lost weight and is more mobile. He needs to get back to the Adult Day Health Care Center to preserve his cognition and improve his behavior as well as maintain existing physical stamina. Discussion: Since the issuance of my 11/07/2013 report, I am in receipt of several correspondence documents regarding continued request for the patient's regular attendance at Adult Day Health Care (ADHC). I understand that this request was non-certified. Since the reviewer did not have the opportunity to review Adult Day Health Care Individual Plan of Care report for date of service 03/24/2008-09/01/2008. Therein, the necessary criteria were verified because the patient "has one or more chronic or post acute medical cognitive or mental health condition (s) identified by the participants personal health care provider as requiring monitoring treatment or intervention, without which the participant's condition (s) will likely deteriorate and require emergency department visits, hospitalizations, or other institutionalization." The medical necessity revolving around my repeated request has been established for many years now. As

Nurse Case Manager notes in her 07/05/2013 Medical Management Program Progress Report the patient was initially placed in "a very costly assisted living facility," for over a decade. He was only transferred to a less costly board and care facility provided he would receive regular ADHC services with social interaction activities, occupational therapy and physical therapy to the cervical spine and shoulders. Provision of ADHC services have been in place since he left [REDACTED], in order to preserve his cognition, as well as maintain his physical health. Should the patient continued to be denied regular attendance to these ADHC services; he will require transfer back to [REDACTED]. Recommendations: Regular attendance at Adult Day Health Care (ADHC) and activity center. The ADHC services should include physical therapy to cervical spine and shoulders due to severe and worsening kyphosis, as well as occupational therapy twice per week to provide stimulation and strength maintenance activities, especially for the neck, to counteract worsening scoliosis. Diagnoses: 1. Severe brain, cervical spine and right upper extremity trauma. 2. Severe post-traumatic frontal lobe organic brain syndrome. 3. Bifrontal post-traumatic encephalomalacia. 4. Probably middle ear trauma. 5. Right phantom limb syndrome. 6. Severe post traumatic brachial plexopathy. 7. Severe cervical dystonia. 8. Multilevel cervical disease. 9. Neurogenic bladder. 10. Severe cardiac disease. 11. Multiple internal complaints.

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

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

#### **ADULT DAY HEALTHCARE 2X A WEEK X 6 MONTHS: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation [http://jnnp.bmj.com/content/73/suppl\\_1/i3.full](http://jnnp.bmj.com/content/73/suppl_1/i3.full). J Neurol Neurosurg Psychiatry 2002; 73:i3-i7 DOI:10.1136/jnnp.73.suppl\_1.I3. Acute Head Injury for the Neurologist, P.J. Hutchinson, P.J. Kirkpatrick; MDA Internet Duration Guidelines by Presley Reed, MD, brain injury rehabilitation.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Head, Interdisciplinary Rehabilitation Programs, Multidisciplinary Community Rehabilitation, Multidisciplinary Institutional Rehabilitation.

**Decision rationale:** According to ODG - Recommended - Interdisciplinary rehabilitation programs range from comprehensive integrated inpatient rehabilitation to residential or transitional living to home or community based rehabilitation. All are important and must be directed and/or overseen by a physician board certified in psychiatry or another specialty, such as neurology, with additional training in brain injury rehabilitation. All programs should have access to a team of interdisciplinary professionals, medical consultants, physical therapists, occupational therapists, speech-language pathologists, neuropsychologists, psychologists, rehabilitation nurses, social workers, rehabilitation counselors, dieticians, therapeutic recreation specialists and others. The individual's use of these resources will be dependent on each person's specific treatment plan. All phases of treatment should involve the individual's family/support system. Multidisciplinary community rehabilitation - Recommend return to activity in the community. Multidisciplinary community rehabilitation may include telephone counseling,

education of the patient and his/her family, along with supportive counseling regarding emerging problems at work or at home, self-instructional training and support groups, all of which have been shown to be effective in improved overall outcome, particularly for functional status and quality of well-being for patients with traumatic brain injury. Multidisciplinary institutional rehabilitation - Under study. Insufficient evidence exists to determine the effectiveness of multidisciplinary post-acute rehabilitation programs for patients with moderate to severe traumatic brain injury (TBI), a new AHRQ Effective Health Care Program review concludes. Interventions that could be classified as comprehensive holistic day treatment programs were the most often studied model of care. These interventions are characterized as integrated intensive programs delivered to cohorts of patients focusing on cognitive rehabilitation and social functioning. Eight studies that addressed primary outcomes and were assessed to have a low or moderate risk of bias were graded to evaluate effectiveness and comparative effectiveness. There was insufficient evidence on effectiveness. According to the medical records, the patient has history of significant trauma from an injury in 1977. His resulting ongoing diagnoses are: Severe brain, cervical spine and right upper extremity trauma; Severe post-traumatic frontal lobe organic brain syndrome; Bifrontal post-traumatic encephalomalacia; Probably middle ear trauma; Right phantom limb syndrome; Severe post traumatic brachial plexopathy; Severe cervical dystonia; Multilevel cervical disease; Neurogenic bladder; Severe cardiac disease; and Multiple internal complaints. According to the medical records, the patient was initially placed in "a very costly assisted living facility," for over a decade, and was only transferred to a less costly board and care facility provided he would receive regular ADHC services with social interaction activities, occupational therapy and physical therapy to the cervical spine and shoulders. It is reported that the services provided at the Adult Day Health Care Center are those of nursing, personal care, social services, therapeutic activities related to occupational and physical therapy as well as meal service. It is suggested that he needs to get back to the Adult Day Health Care Center to preserve his cognition and improve his behavior as well as maintain existing physical stamina. The records provided indicate that the patient had previously been attending Adult Day Health Care (ADHC) for over a year. There does not appear to be any documentation demonstrating subjective and objective functional gains obtained with the long-term participation within this program. There also does not appear to be any detailed outline of the planned course of care to be provided to the patient should he return to the ADHC. In addition, it is unclear why the patient could not complete therapeutic activities with routine physical therapy. It is not felt that the medical records have adequately established that the patient had obtained clinically significant improvement with prior placement in the ADHC, a thoroughly detailed treatment plan has been provided, and that a return to access to the facility will lead to further gains. The medical necessity of the request has not been established.