



Case Number:	CM13-0066815		
Date Assigned:	01/03/2014	Date of Injury:	08/30/2010
Decision Date:	05/23/2014	UR Denial Date:	11/22/2013
Priority:	Standard	Application Received:	12/17/2013

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 Occupational 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 patient is a 36-year-old male who was injured on 08/30/2010. He was hit by a car on the freeway while trying to repair another car. He had multiple fractures to the skull, orbit and subdural hematoma. Prior treatment history has included [REDACTED] brain injury program (discharged 09/18/2013). He received caregiver support in the evenings and through the night. He has completed 23 neuropsychology visits and [REDACTED] has completed an evaluation plus 3 additional visits. He has received rehabilitation, aquatic therapy, day treatment program on 09/22/2010; then transferred to [REDACTED] on 12/11/2011; and [REDACTED] on 01/09/2012 to 05/08/2013. [REDACTED] plan of care dated 11/14/2013 indicates the patient is living at home with his family. He currently has trouble sleeping. His primary complaints are pain (headaches), anxiety, anger management and poor memory. He would like to return to work. The patient needs continued cues and assistance with establishing this productive day. The clinical team is recommending an expansion of the home and community program to assist the client in a successful transition. An authorization is requested for a referral to outpatient physical therapy, continue speech therapy 1 visit per week for 5 weeks and interpreter to address money management and attending to his productive day schedule; initiate occupational therapy 1 visit per week for 6 weeks to assist with community resources; and marriage and family counseling 12 sessions to address communication challenges. Multidisciplinary report dated 09/09/2013 indicates the patient is in a stabilized mood; He spent 6 years of school in [REDACTED] and worked as an auto mechanic. His wife is his caregiver and he is independent with his wife and children. On cognition, the patient has a neuropsychological profile consistent with traumatic brain injury. More specifically, he has difficulty with inhibition, working memory, and attention. His ability to participate in formal neuropsychological assessment was negatively impacted by having headache. Occupational Therapy Progress Note

dated 09/09/2013 include: His admit status for occupational therapy on 07/30/2013 states the patient is unable to report what he does during the day when at home. He used to work in the auto industry. His goals were not met. On progress note dated 09/09/2013 indicates the patient demonstrates continued difficulty with memory recall. The patient demonstrates limited endurance during sessions intermittently, complaining of headaches. The client refused 1 of 3 OT sessions in the previous week. His goal is to identify two hobbies that he can complete modified independently while at home. Speech Therapy Progress note dated 09/09/2013 include: As it pertains to speech therapy, the patient is required to have supervision at home and in the community due to max A required for recall and safety. He requires cues to arrive on time to therapy, to recall newly learned information and events post 24 hours, and to apply learned memory strategies (journal and note-taking). On cognition, the patient has a neuropsychological profile consistent with traumatic brain injury. More specifically, he has difficulty with inhibition, working memory, and attention. His ability to participate in formal neuropsychological assessment was negatively impacted by having headaches.

IMR ISSUES, DECISIONS AND RATIONALES

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

FIVE OCCUPATIONAL THERAPY SESSIONS FOR MONEY MANAGEMENT AND ATTENDING TO DAILY SCHEDULE FOLLOWING HEAD INJURY: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Head, Occupational Therapy (OT)/Physical Medicine Treatment

Decision rationale: CA MTUS guidelines do not specifically discuss the issue in dispute and hence ODG have been consulted. As per ODG, "physical medicine treatment is recommended for patient rehabilitation after traumatic brain injury and divided into three periods: acute, subacute and postacute. In the beginning of rehabilitation the physical therapist evaluates patient's functional status, later he uses methods and means of treatment, and evaluates effectiveness of rehabilitation. Physical therapy consists of prevention of complications, improvement of muscle force, and range of motions, balance, movement coordination, endurance and cognitive functions." ODG recommends allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home PT. In this case, the medical records document that this patient has undergone extensive treatment to date as a result of his traumatic brain injury. The request is for occupational therapy sessions x5 to assist with community resources for a productive day with interpreter. The medical records do not indicate progress with prior rendered therapy as to substantiate that the additional sessions would likely be beneficial at this point. A progress note dated 11/14/2013 indicates that the patient continued to have trouble sleeping, headaches, anxiety, anger management, and poor memory. The medical necessity of the requested additional occupational therapy sessions x5 have not been established. Therefore the request is not medically necessary and appropriate.