

Case Number:	CM14-0000317		
Date Assigned:	01/10/2014	Date of Injury:	01/28/2008
Decision Date:	04/22/2014	UR Denial Date:	12/27/2013
Priority:	Standard	Application Received:	01/02/2014

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 Physical Medicine and Rehabilitation and is licensed to practice in California and Virginia. 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 46 year old female who was injured on 01/28/2008. The patient was injured when a shackle broke loose and came across her eyes, crushing her nose, left eye socket and left upper jaw. She was reported she was knocked back three or four feet to her knees. Prior treatment history has included orthodontic treatment, ice/heat, soft diet, occlusal stabilization appliance, psychotherapy, physical therapy, and Cymbalta. Her medication history included Norco, Effexor, Verapamil, Meclizine, and Kenalog injections to The patient is a 46 year old female who was injured on 01/28/2008. The patient was injured when a shackle broke loose and came across her eyes, crushing her nose, left eye socket and left nasal scar. The patient underwent surgical repair of facial fractures with multiple titanium plates and screw on 01/30/2008. Office note dated 09/19/2013 indicated the patient was in for a follow up of TBI associated with multiple facial fractures. The patient had malocclusion which required bracing early on, frontal lobe syndrome, memory/cognitive/judgment/insight deficits, volatility of mood, depression, anxiety with panic, and headaches. The patient was no longer on her medications as they were not covered by her carrier. The patient was hysterical with panic, sadness, and anger. She continued to have poor sleep and has lost weight as she had no appetite. She has not seen a dentist and still had bruxisms. Her headaches have returned and she had constant double vision. Her balance remained as issue but she had not fallen. Neck exam revealed cervical lordosis which was straightened and the range of motion was full. There was spasm and pain to palpation of the paraspinous muscles and trapezius areas. The extremity exam revealed no clubbing, cyanosis, or edema. There was bilateral central facial weakness on neuro exam. There was a glabellar response; jaw jerk reflex was not present. The palate was midline. The tongue was midline. There was a gag reflex present. On motor exam, muscle tone was generally increased; strength testing was normal; RAMs were slowed on the right. Muscle spasm was present in the spine. There was triple flexion. There were no tremors; heel to shin testing was intact. The patient could do a tandem walk. The patient could walk on her heels and toes; gait and station

were wide-based and not antalgic. The patient was diagnosed with 1) TBI with facial bone fractures; 2) Frontal lobe syndrome and OBS; 3) Post traumatic headaches; 4) Depression, anxiety, and possible BPD II; 5) Dental malocclusion; 6) Possible obstructive and/or central sleep apnea. Office note dated 04/11/2013 indicated the patient was in for follow-up of TBI. The patient had been having difficulty with "motivation" and had been sad. She had not been suicidal. She was sleeping too much and has gained weight.

IMR ISSUES, DECISIONS AND RATIONALES

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

GYM MEMBERSHIP: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Treatment Index, 9th Edition (web), Gym membership.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Physical Medicine and Rehabilitation, 3rd Edition, 2007 Chapter 19: Therapeutic Exercise, pages 413 – 436.

Decision rationale: There are no current MTUS Guidelines for the prescription of Gym Memberships in the treatment of post-brain injury rehabilitation and recovery. However, current recommendations for the prescription of therapeutic exercise as part of a functional recovery program include having specific guidelines for treatment, including frequency of participation, intensity of exercise, duration, goals, and re-evaluation. None of these items are documented or discussed in the records. Based on the lack of consensus guidelines and lack of documentation, this request is non-certified.