

Case Number:	CM14-0056381		
Date Assigned:	07/09/2014	Date of Injury:	12/07/2012
Decision Date:	11/20/2014	UR Denial Date:	04/11/2014
Priority:	Standard	Application Received:	04/25/2014

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 Family Medicine and is licensed to practice in Ohio. 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 is a 48 year old female who was involved in a motor vehicle accident 12-07-2012. She sustained several serious injuries and has had nearly 20 surgeries after the accident. Her diagnoses include traumatic brain injury, subarachnoid bleed, cognitive deficit, cerebral contusion, left brachial plexus injury, multiple pelvic fractures, left tibia fracture, and right femur and left foot fractures. After release from the hospital, she has been getting multi-modal therapy as an inpatient to include cognitive therapy, speech therapy, occupational therapy, and speech therapy. It appears that roughly on 4-9-2014 she was transitioned to home but continued to require multi-modal therapy as an outpatient and residential training. Her exam reveals persistent cognitive deficits, swelling in the left leg, atrophy of the left hand, painful range of motion of the left shoulder, and palpable masses of the left biceps and left shin regions.

IMR ISSUES, DECISIONS AND RATIONALES

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

Clinic therapy five (5) hours a day, three (3) days a week: Overturned

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

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

Decision rationale: 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 physiatry 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. Insufficient evidence exists to determine the effectiveness of different multidisciplinary post-acute rehabilitation programs for patients with moderate to severe traumatic brain injury (TBI), an AHRQ Effective Health Care Program review concludes. There was a low level of evidence that certain interventions were no different than others in terms of productivity outcomes at 1-year post-treatment. There was a low level of evidence that a comprehensive holistic day treatment program resulted in greater productivity, but not improved community integration, than the standard treatment. However, group differences no longer existed at 6 months post-treatment because the standard rehabilitation group made significant progress during the follow-up period. Gains made during rehabilitation appear to be sustained at follow-ups 6 months to 1 year post-treatment. One study addressed harms and found no treatment-related harms. According to this systematic review, the available evidence for different types of TBI multidisciplinary rehabilitation programs does not prove the superiority of one approach over another. In this instance, there is general documentation that the injured worker has made substantial gains. The frequency of therapy requested, 3 days a week and not 4 days a week, represents a reduction from previous levels. While specific documentation of functional gains and residual deficits are lacking, the inclusion of such would likely necessitate several thousand documents. Because there have been gains by general documentation and inference from a reduced therapy frequency request, and because these programs have been shown to result in greater productivity than standard treatment, clinic therapy five (5) hours a day, three (3) days a week is medically necessary.

Residential training twelve (12) hours a day, seven (7) days a week: Overturned

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Head, Multidisciplinary community rehabilitation

Decision rationale: The Official Disability Guidelines recommend return to activity in the community. Multidisciplinary community rehabilitation may include 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. In this instance, the injured worker is transitioning from an exclusively inpatient program to an outpatient program. However, she continues to possess substantial cognitive and physical deficits and needs assistance, primarily at nighttime. Therefore, for Residential training twelve (12) hours a day, seven (7) days a week is medically necessary.