

<b>Case Number:</b>	CM14-0068736		
<b>Date Assigned:</b>	07/14/2014	<b>Date of Injury:</b>	12/07/2012
<b>Decision Date:</b>	12/30/2014	<b>UR Denial Date:</b>	04/29/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/13/2014

### 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, has a subspecialty in Interventional Spine 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 48-year-old female with a date of injury of 12/07/2012. According to progress report 04/01/2014, the patient was involved in a head-on motor vehicle accident on 12/07/2012 and suffered a traumatic left brachial plexus lesion and multiple fractures to her pelvis, left tibia, right femur, and right foot at the metatarsal. She currently presents with increased pain in the left arm and has noticed some swelling. Examination revealed a grade 2 subluxation of the left shoulder as well as atrophy distally in the left hand. There is a soft palpable mass in the biceps area that is non tender. There is pain associated with range of motion and palpation at the shoulder girdle and dorsal hand. The left leg has palpable nodule on the left medial shin, and there is some noted discoloration. There is diminished sensation in the left forearm and hand and no motor control of the left upper extremity. DTRs are absent. The listed diagnoses are: 1. Traumatic closed head injury with subarachnoid hemorrhage right anterior frontal distribution. 2. Bilateral frontal parietal diffuse axonal injury. 3. Left upper extremity plexopathy. 4. History of multiple pelvic fracture status post close reduction fixation on 12/28/2012. 5. Right sciatic nerve traction injury. 6. History of left tibial fracture status post ORIF. 7. History of right femur fracture status post intramedullary nail placement. 8. Right metatarsal fracture, status post ORIF. 9. History of liver laceration, status post multiple transfusions. 10. DVT above the left upper extremity and left internal jugular vein. 11. Rule out left bicep tendon rupture. The treater is requesting [REDACTED] Program, 24-hour home care, gym membership, and periodic behavioral management review. The utilization review denied the requests on 04/29/2014. Treatment reports from 06/07/2013 through 08/27/2014 were provided for review.

## IMR ISSUES, DECISIONS AND RATIONALES

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

### **Continued Multidisciplinary Rehabilitation (unspecified duration): Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM. ODG GUIDELINES

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Chronic pain programs (functional restoration programs) Page(s): 30-32.

**Decision rationale:** This patient presents with increased pain in her left upper extremities. The current request is for continued multidisciplinary rehabilitation (unspecified duration), per report 04/01/2014. Regarding additional participation in a Functional Restoration Program, the MTUS Guidelines page 30-33 states, "Treatment duration in excess of 20 sessions requires a clear rationale for the specified extension and reasonable goals to be achieved. Longer durations require individual care plans and improvement outcomes, and should be based on chronicity of disability and other known risk factors for loss of function." Report 01/29/2014 notes that the patient remains categorized as "catastrophic but somewhat stable..." The patient is considered at "high risk of regression if rehab is discontinued too soon." Short-term and long-term goals were address. It was noted that patient has been participating in the [REDACTED] Program since 04/09/2013. The treating physician mentions that the patient has "indeed improved in all areas of concerns; however, we will continue to need extensive rehabilitation program while the transition from inpatient to outpatient is in progress." He is recommending patient continue with multidisciplinary rehabilitation as the patient "remains with significant deficits in relation with her safety judgment, impulsivity, and poor generalization/carry over of skill training to daily skills, necessitating continued need." In this case, an open-ended request for continued treatment in a multidisciplinary rehabilitation program cannot be supported. Furthermore, the patient has had 20 surgeries following her motor vehicle accident and the treating physician feels that the "patient most likely will need further surgical intervention." FRP is indicated for patient's that are not candidates for further surgery. The current request does not specify if the patient requires additional inpatient rehabilitation or if this request is for initial outpatient rehabilitation or continuance of outpatient rehabilitation. In this case the treating physician has not documented the criteria needed to participate in an inpatient pain rehabilitation program and an open request with no specific frequency or duration of an outpatient program is not supported by the MTUS guidelines. Treatment is not medically necessary and appropriate.

### **24-Hour Supervision (unspecified duration): Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM. ODG GUIDELINES

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines home health services Page(s): 51.

**Decision rationale:** This patient presents with increased pain in her left upper extremities. The current request is for a 24-hour supervision, per report 04/01/2014. The treating physician states that the patient requires 24-hour caregiver support at night "for her safety and to monitor medication administration." The utilization review modified the certification from the requested 24-hour supervision to 16-hour supervision for 1 month. The MTUS Guidelines page 51 states that home health services are recommended only for otherwise recommended medical treatment for patient's who are home bound, on a part-time or "intermittent" basis, generally up to no more than 35 hours per week. In this case, the patient does appear to have significant continued deficits and some mental issues as documented in report 4/1/14. The treater states that the patient has limited awareness of deficit, impaired safety judgment, defensiveness, and some emotional liability. Recommendation for "24-hour supervision" cannot be supported as MTUS recommends no more than 34 hours per week. In addition, the treater does not specify the duration of the requested treatment. Without a specific time frame for the duration of this request the requested 24 hour supervision cannot be considered. Treatment is not medically necessary and appropriate.

**GYM membership (unspecified duration):** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM. ODG GUIDELINES

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder (Acute & Chronic) chapter, Gym memberships

**Decision rationale:** This patient presents with increased pain in her left upper extremities. The current request is for gym membership. Gym memberships are not specifically addressed in ACOEM. However, ODG guidelines state it is not recommended as a medical prescription. Treatments need to be monitored and administered by medical professionals. While an individual exercise program is recommended, outcomes that are not monitored by a health professional, such as gym memberships or advanced home exercise equipment is not recommended and not covered under this guideline. Treatment is not medically necessary and appropriate.

**Periodic Behavior Management Review:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM. ODG GUIDELINES

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Behavioral interventions Page(s): 23.

**Decision rationale:** This patient presents with increased pain in her left upper extremities. Current request is for periodic behavioral management review. The Utilization review modified the certification from to "periodic behavioral management review times 3 visits." For cognitive behavioral therapy, the California Medical Treatment Utilization Schedule (MTUS) Guidelines page 23 recommends an initial trial of 3 to 4 psychotherapy treatments over 2 weeks and

additional treatments for a total of 6 to 10 visits with documented functional improvement. In this case, the medical file provided for review indicates that the patient has been participating in a Multidisciplinary program since 2013. Behavioral therapy reports are not provided for review. In this case, the treater does not provide documentation of functional improvement from prior sessions to consider additional treatment. Treatment is not medically necessary and appropriate.