

<b>Case Number:</b>	CM14-0185399		
<b>Date Assigned:</b>	11/13/2014	<b>Date of Injury:</b>	03/24/2010
<b>Decision Date:</b>	12/19/2014	<b>UR Denial Date:</b>	10/07/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/06/2014

### 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 Internal 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 an injured worker with a history of cervical spine injury and depression. Qualified medical examination report dated 6/8/14 documented that the patient injured his cervical spine through a sequence of events, starting with a work related incident on 1/10/10 and continuing with another work related incident on 3/24/10. On 3/26/10, the patient underwent a left sided Smith-Robinson anterolateral approach to the cervical spine with C5-C6 vertebrectomy, C4-C5, C5-C6, and C6-C7 discectomy and foraminotomy, C4-C7 anterior interbody arthrodesis with fibular allograft and local allograft. On 3/29/10, he underwent surgery that included a posterior approach to the cervicothoracic spine from C4-T2. He had C5-C7 laminectomy, C4-T2 posterolateral arthrodesis with local autograft, rhBMP-2 and MasterGraft. Medications included Valium, Robaxin, Baclofen, Lyrica, Vicodin, Norco, Milk of Magnesia, Colace, Lactulose, Oxybutynin, Flomax, D-Mannose, Lotensin, Coreg, Abilify, Doxepin, Seroquel, Cymbalta, and Zofran. Physical therapy progress note dated 9/22/14 documented that the patient walked 884 feet. Occupation therapy progress note dated 9/22/14 documented that patient has taken a leadership role in lawn games and participated in meal planning, bed making, and community outings. Neuropsychology progress note dated 9/22/14 documented suicidal ideation. Date of admission to the [REDACTED] was 09-02-2011. The psychiatric consult report dated October 1, 2014 documented the patient has been enrolled in a [REDACTED] for the past three years. The patient reported subjective complaints including depression and anxiety. He has chronic back pain and lower extremity weakness and numbness. The patient is able to perform activities of daily living, including housekeeping, shopping, transportation, meal preparation, telephone use, bathing, getting dressed, toileting, independent transfers, eating and cooking. Past medical history was significant for traumatic brain injury, suicidal attempt, C6-C7 incomplete spinal cord injury, neurogenic bowel, neurogenic bladder, hypertension, chronic low

back pain, and hypertension. Objective findings were documented. The patient was clean and adequately dressed and groomed. The patient was ambulating with a four-point walker. He was calm, cooperative, with good eye contact. Speech fluency, rate, rhythm, volume and tone are all within normal limits. Mood was depressed. He smiled and laughed appropriately at times. Diagnoses were traumatic brain injury and major depressive disorder. The treatment plan included Seroquel, Cymbalta, and Abilify. Continuing [REDACTED] multidisciplinary residential program from 9/26/14 through 10/24/14 with 1:1 one-to-one supervision 24 hours per day was requested.

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

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

**[REDACTED] Residential Program, Post-Acute Physical Rehab, with 1 on 1 Supervision x 28 days: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Chronic pain programs (functional restoration programs) Functional restoration programs (FRPs),.

**Decision rationale:** Medical Treatment Utilization Schedule (MTUS) Chronic Pain Medical Treatment Guidelines addresses multidisciplinary programs. Chronic pain programs are also called multidisciplinary pain programs, interdisciplinary rehabilitation programs, or functional restoration programs (FRP). These pain rehabilitation programs combine multiple treatments. Patients should be motivated to improve and return to work, and meet the patient selection criteria outlined below. Criteria for the general use of multidisciplinary pain management programs were presented. Outpatient pain rehabilitation programs may be considered medically necessary when all of the following criteria are met: (1) An adequate and thorough evaluation has been made, including baseline functional testing so follow-up with the same test can note functional improvement; (2) Previous methods of treating chronic pain have been unsuccessful and there is an absence of other options likely to result in significant clinical improvement; (3) The patient has a significant loss of ability to function independently resulting from the chronic pain; (4) The patient is not a candidate where surgery or other treatments would clearly be warranted; (5) The patient exhibits motivation to change, and is willing to forgo secondary gains, including disability payments to effect this change; & (6) Negative predictors of success have been addressed. Access to programs with proven successful outcomes is required. Treatment is not suggested for longer than 2 weeks without evidence of demonstrated efficacy as documented by subjective and objective gains. Longer durations require individualized care plans and proven outcomes, and should be based on chronicity of disability and other known risk factors for loss of function. Medical records document that the patient was admitted on 09-02-2011 to the [REDACTED] multidisciplinary residential program. The patient has been a resident of the [REDACTED] for three years. Continuing the [REDACTED] [REDACTED] multidisciplinary residential program from 9/26/14 through 10/24/14 with 1:1 one-to-one supervision 24 hours per day was requested. MTUS indicates that multidisciplinary rehabilitation treatment is not suggested for longer than 2 weeks. Longer

durations require evidence of demonstrated efficacy. MTUS indicates that extensions are limited to 2 week periods. Therefore, the request for 28 days of participation in the [REDACTED] [REDACTED] multidisciplinary residential program is not supported. Therefore, the request for [REDACTED] Residential Program, Post-Acute Physical Rehab, with 1 on 1 Supervision x 28 days is not medically necessary.