Case Number:	CM13-0036491		
Date Assigned:	12/13/2013	**Date of Injury:**	03/04/2008
Decision Date:	02/03/2014	**UR Denial Date:**	10/07/2013
Priority:	Standard	**Application Received:**	10/21/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Psychiatry 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 physician 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:

This case involves a 42 year old male who is currently being treated for symptoms related to Soft Tissue-Head, Soft Tissue-Neck, Upper Back Area, Upper Ann (Left) and Shoulder (Left). The patient has a date of injury on 03/04/08. The mechanism of injury is not reviewed. He is currently not working. Denied Body Parts: Elbow (Left), Shoulder (Right), and Mental/Physical The patient has a 5-year history of traumatic brain injury with associated emotional distress and cognitive dysfunction with reported functional benefit from 89 sessions of cognitive retraining as of 9/24/13, and was noted to be near treatment discharge at that time .10 additional sessions of cognitive retraining were approved in UR on 9/24/13 with recommendation of discharge from additional sessions of cognitive retraining.

IMR ISSUES, DECISIONS AND RATIONALES

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

Neuropsychological Testing (hours), Qty 15: 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 Chapter, section on Postconcussion Syndrome.

Decision rationale: The CA MTUS is silent on neuropsychological testing. The Official Disability Guidelines ODG -TWC ODG Treatment Integrated Treatment/Disability Duration Guidelines Head Chapter (trauma, headaches, etc., not including stress & mental disorders) Postconcussion Syndrome Approximately 38% of patients who sustain head trauma characterized by a brief disturbance of consciousness and clinically unremarkable neuroradiologic findings meet International Classification of Diseases 10th edition (ICD-10) diagnostic criteria for postconcussion syndrome (PCS). Symptoms could involve complaints of irritability, fatigue, headache, difficulty concentrating, dizziness and memory problems. Anxiety and depression are also frequently present, especially later in its course. It is important to remember that symptoms identical to those of postconcussion syndrome are present in a significant number of the normal population: three or more concussion-like symptoms occur in over 80% of non-head injured persons. (Anderson, 2006) While ICD-10 and DSM-IV criteria are similar, there are a number of differences, such as the requirement for evidence from neuropsychological testing. These differences in definition have important implications for the identification and study of PCS. There is, in fact, a low level of agreement between ICD-10 and DSM-IV criteria for the diagnosis of PCS, with a prevalence rate of 11% when using DSM-IV criteria and of 64% when using ICD-10 criteria. This difference was mainly due to fewer patients meeting the DSM-IV criteria for cognitive deficit and clinical significance. (Carr, 2007) Although PCS has often been thought to reflect a psychological response to injury, there is considerable recent evidence to suggest that it is primarily a physiologic disturbance. The DSM-5, however, removes the diagnosis for PCS. The condition is now called "Major or Mild Neurocognitive Disorder Due to Traumatic Brain Injury." Most of the diagnostic criteria are different as compared to the DSM-IV or ICD-10 criteria. Under the new criteria, the disorder must present immediately after the occurrence of the traumatic brain injury or immediately after recovery of consciousness and must persist past the acute post-injury period. (APA, 2013) For most individuals, treatment consists primarily of education of the patient and his/her family, along with supportive counseling regarding emerging problems at work or at home. A subgroup of patients, however, may require psychopharmacologic intervention. Avoid attempts of multiple parallel processing in a postconcussive stage. Widely accepted treatments for post-traumatic headache may include, but are not limited to: interdisciplinary treatment, pharmacology, joint manipulation, physical therapy, massage, acupuncture, biofeedback, psychotherapy and diet. These procedures should only be continued if functional gains are documented. Neuropsychological testing: Recommended for severe traumatic brain injury, but