MAXIMUS Federal Services

Case Number:	CM13-0056873		
Date Assigned:	12/30/2013	Date of Injury:	07/01/2001
Decision Date:	03/31/2014	UR Denial Date:	11/11/2013
Priority:	Standard	Application Received:	11/23/2013

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 Physical Medicine & Rehabilitation 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:

The patient is a 65-year-old male who reported an injury on 07/01/2001. The specific mechanism of injury was not provided. The patient was noted to have multiple strokes. The patient had completed 56 sessions of speech therapy. The office note of 11/01/2013 revealed that the patient was having significant issues in terms of speech and communication following his sustained stroke in 2002. It was indicated that the patient reported difficulty with speech secondary to productive aphasia, and the patient found that speech therapy helped him to formulate sentences and remember specific words. The patient could not speak in full sentences and answered questions by nodding yes or no. The patient had occasional headaches, blurred vision and chronic neck and low back pain. The patient had ongoing weakness in the right side, affecting the arm and leg in comparison to the left. The patient was noted to be treated with cognitive behavioral therapy and speech therapy. Objectively, the patient attempted to communicate with the physician through the production of words and speech and appeared frustrated. The patient made several attempts to try answering questions with a sentence, but could only provide 1 to 2 word answers and shake his head up and down to answer simple questions with a yes or no. The patient was able to follow 2 and 3 step commands without significant difficulty. Formal language was not performed on the visit. The patient had some weakness in the right arm as compared to the left. The patient had slower finger tapping on the right as compared to the left. The patient was able to ambulate without assistance but had difficulty with tandem walking and veered to the right when trying to walk in a straight line. The patient's diagnoses were noted to include other ill-defined cardiovascular disease and aphasia as well as reactive depression. The request was made for 24 visits of speech therapy.

IMR ISSUES, DECISIONS AND RATIONALES

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

Twenty Four (24) speech therapy visits: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG-TWC Head Procedure summary, Speech Therapy and Blue Cross of California Medical Policy DME

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, Speech Therapy .

Decision rationale: Official Disability Guidelines indicate that speech therapy is appropriate for a diagnosis of speech, hearing or language disorder resulting from an injury, trauma or medically-based illness or disease and clinically documented functional speech disorder resulting in an inability to perform at the previous functional level. Documentation should support an expectation by the prescribing physician that measurable improvement is anticipated in 4 to 6 months and that the level of complexity of the services requested can only be rendered safely and effectively by a licensed speech pathologist and language pathologist or audiologist, and treatment beyond 30 visits requires authorization. The clinical documentation submitted for review indicated that the patient had 56 visits of previous speech therapy. There was a lack of documentation of the patient's previous functional level. There was a lack of documentation indicating that the physician anticipated that the patient would have measurable improvement in 4 to 6 months. The patient had dysarthria and significant speech production difficulties secondary to his brain ischemic injury of a sustained stroke in 04/2002. Given the above, the request for 24 sessions of physical therapy is not medically necessary and appropriate.