

| | | | |
|-----------------------|--------------|------------------------------|------------|
| Case Number: | CM13-0067620 | | |
| Date Assigned: | 01/03/2014 | Date of Injury: | 10/17/2012 |
| Decision Date: | 04/15/2014 | UR Denial Date: | 12/09/2013 |
| Priority: | Standard | Application Received: | 12/18/2013 |

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 Occupational 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 a 48-year-old male who was injured on 10/17/2012 when he fell over 25 ft into an elevated shaft. Prior treatment history has included (list prior treatments). The patient underwent a right hemisectomy and evacuation of the right subdural hematoma and intraparenchymal clot, repair comminuted skull fracture and complex scalp laceration on 10/17/2012. 01/15/2014 Medications Include: Cymbalta 60 mg Capsule Duexis 800; 26.6 mg tablet Diagnostic studies reviewed include MRI of face without contrast performed on 12/02/2013 revealed the following: 1) Mild asymmetry with mild subtle prominence of the subcutaneous fat in the right cheek with adjacent focal metal susceptibility artifact most consistent with postsurgical change; this is likely the region of clinical concern. 2) The underlying zygoma bone appears intact without a fracture deformity or hypertrophy and is symmetric in appearance to the left zygoma. 3) There is diffuse fatty replacement and absence of the normal right parotid gland, query postsurgical change, post-trauma or chronic denervation changes (CN V3), correlate with priors. 4) Postsurgical findings of a right craniotomy 5) There are findings of volume loss 6) Encephalomalacia and gliosis in the right temporal lobe most consistent with postsurgical change and sequelae of chronic injury 7) There is a probable small thin extra axial fluid collection that is likely a hygroma fluid signal in this region of the right temporal convexity without mass effect or midline shift; correlation with prior images if available to evaluated for interval stability is recommended. 8) Hypoplastic left maxillary sinus with mucosal thickening with proteinaceous/mucinous secretions and a small air-fluid level in the right maxillary sinus and mucosal thickening in the frontal and ethmoidal sinuses; nonspecific partial opacification of the right mastoid air cells is present signed by [REDACTED]. MRI of the brain performed on 10/23/2012 revealed the following findings: 1) Expected post surgical changes of right hemisectomy with extra axial fluid collection and

subgaleal hematoma. 2) There is swelling of the right cerebral hemisphere with external herniation through craniectomy defect. 3) Hemorrhagic contusion in bilateral temporal lobes with dominant right contusion and smaller left sided injury 4) Additional small foci of contusion injury within right temporal lobe and cerebellum 5) Mild herniation 6) Left frontal ventricular catheter with (tip a) foramen of Monroe 7) Nonspecific foci of white matter 8) Hyperintensity which may represent non-hemorrhagic trauma or axonal injury MRI of the cervical spine performed on 08/18/2012 revealed no abnormalities of the cervical spinal cord; soft tissue edema surrounds the nuchal ligament near the occipital protuberance. PR2 dated 12/04/2013 indicated [REDACTED] rated his pain as 7 on a scale of 0 to 10. He has noted that the right side of his face along the cheekbone swells mostly in the afternoon. This is painful and it goes down over night. He continues to report pain along the right scalp and temple. He also has pain along the neck with the most extension in to the upper back to the scapular area and down the right arm. He notes one incident unable to grasp or pick up a glass. He is sleeping okay. There are no nightmares. He is able to dress himself and do things around the house but is unable to mow the lawn. He has episodic vertigo that is not positional. He is not driving. Objective findings on exam revealed the patient appeared to be anxious. He does not show signs of intoxication or withdrawal. He has an antalgic gait. He has cervical facet tenderness at C2-C3, C4-C5, mostly along the right Spurling's maneuver; produces no pain in the neck musculature or radicular symptoms in the arm. All upper limb reflexes are equal and symmetric. His motor examination is grossly normal for bilateral upper

IMR ISSUES, DECISIONS AND RATIONALES

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

EMG CERVICAL /UPPER EXTREMITIES: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS Citation: American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004), Electromyography, as well as Official Disability Guidelines (ODG), Low Back-Lumbar & Thoracic (Acute & Chronic) Electromyography.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS Citation: American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004), Electromyography, as well as Official Disability Guidelines (ODG), Electromyography.

Decision rationale: The patient does not have complaints of upper extremity radicular pain or weakness. There is mention of patchy bilateral upper extremity numbness. There are no radicular findings on exam. A prior cervical MRI appears to be without nerve impingement. No specific suspected diagnosis or rationale is provided for this study. Medical necessity has not been established. EMG cervical/upper extremities is non-certified.