

Case Number:	CM13-0070550		
Date Assigned:	01/08/2014	Date of Injury:	11/03/2012
Decision Date:	04/14/2014	UR Denial Date:	11/27/2013
Priority:	Standard	Application Received:	12/24/2013

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 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 a 65-year-old who was injured on 11/03/2012. The patient has an unknown mechanism of injury. Prior treatment history has included 36 authorized physical therapy visits for her right shoulder, home exercise program at least 3 times a day and medication therapy. Operative report dated 06/10/2013 revealed the patient had a subacromial decompression. Diagnostic studies reviewed include VNG examination on 10/30/2013 which revealed abnormal VNG (right unilateral peripheral reduction). PR2 dated 09/04/2013 indicated the patient is not sure if she has had an MRI of the brain. The patient stated that she has had hearing loss in the right ear since the event. The patient complained of tinnitus in the ear. There was no otalgia, otorrhea, but stated that she continued to have a sensation of vertigo. The patient had no history of ear infections or symptoms. PR2 dated 10/09/2013 indicated the patient was being seen by ENT for balance issues, left ear. Objective findings on exam revealed flexion: passive at 165 degrees, abduction 165 degrees; and marked weakness. PR2 dated 11/06/2013 documented the patient to have complaints of persistent shoulder pain. The patient continues to have a humming sound in the right ear. The patient states that the left ear is the better hearing ear. There was no otalgia. The patient states that she continues to have the vertigo as well. The patient complains of right sided nasal congestion and rhinorrhea as well. Objective findings on exam revealed flexion 170 degrees; abduction 130 degrees; with weakness in the deltoid. On HEENT exam, auricle atraumatic with no noted lesions; ear lobe had no masses or lesions; ear canals were normal with no lesions. The right tympanic membrane was intact with normal mobility. The left tympanic membrane was intact with normal mobility. The nose had clear discharge. The nasal septum was midline and turbinates were hypertrophic. A physical therapy note dated 11/21/2013 documented the patient to have complaints of shoulder pain but she does not take the pain medications anymore. The patient just uses the cream her MD gave her. The patient has good

and bad days because of the pain and is going to the gym to do her home exercise program there. Objective findings on exam revealed limited AROM, though full PROM. The patient's AROM is limited secondary to pain and some shoulder weakness. Overall, the patient has made slow gains with physical therapy, but is now able to manage her symptoms independently with her home exercise program. Therefore, The patient was discharged from physical therapy. [REDACTED] of ENT and Facial Plastic Surgery with the [REDACTED], indicated on clinic note dated 10/30/2013 that the patient stated she experienced no hearing loss or balance difficulties prior to the trauma. The patient stated, after the head trauma, the episodes of dizziness and strength of the tinnitus continue to increase and The patient feels her hearing has decreased. The patient finds to look up or turn the head real quick, feel short spells of off-balance will occur. The patient denied episodes of true vertigo when changing head or body position. The patient denied family history of hearing loss or Meniere's disease. The patient's otologic history was reported as remarkable for SNHL diagnosed in her prior audiogram.

IMR ISSUES, DECISIONS AND RATIONALES

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

ONE COMPUTED TOMOGRAPHY (CT) SCAN OF THE TEMPORAL BONE: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

Decision rationale: The documentation provided does not provide a history or physical exam to indicate necessity for CT of the temporal bone. The patient complains of dizziness and tinnitus. According to the ODG guidelines, a CT scan is recommended for abnormal mental status, focal neurological deficits, acute seizure, signs of basilar skull fracture, evidence of physical trauma above the clavicles, along with several other special circumstances. The request for one computed tomography scan of the temporal bone is not medically necessary or appropriate.