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| Case Number: | CM14-0005778 | | |
| Date Assigned: | 02/05/2014 | Date of Injury: | 07/08/2008 |
| Decision Date: | 06/20/2014 | UR Denial Date: | 12/24/2013 |
| Priority: | Standard | Application Received: | 01/13/2014 |

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 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 claimant was injured on 07/06/06 when he fell 10 feet from a ladder and struck his head, sustaining a traumatic brain injury. He was unconscious for four days. On 10/31/13, he was evaluated for difficulty chewing. He had a dislocated and inflamed disc in the TMJ per an MRI report. On 11/14/13, he saw [REDACTED] but there was no mention of dizziness or vertigo at that time. Jaw surgery was recommended. He saw [REDACTED] on 12/16/13 for a comprehensive neurological evaluation. He underwent brain surgery. He lost the sight in his left eye. He complained of pain in his head with dizziness, vertigo, and dysequilibrium and had pain and weakness in his bilateral hands and fingers. He had constant pain in his back and forgetfulness and difficulty concentrating. He had trouble sleeping. There is no mention of hearing loss. He had tenderness of the neck and shoulders with spasm but good range of motion. Tinel's and Phalen's tests were negative. His low back was also tender. He had no focal neurologic deficits but did have a wide-based stride. Sensation was intact and deep tendon reflexes were intact. He has been assessed with a traumatic brain injury, neurocognitive deficits, and major depressive disorder with psychotic features. He also has headaches and TMJ dysfunction. A complete audiology evaluation was recommended due to the fact that he had lost his hearing and needed to have it reevaluated. This has been a problem in the past. The note later states he does not have difficulty with hearing. The rehab hospital had stated he had problems with his hearing. The list of diagnoses by [REDACTED] does not include problems with hearing. There is no documentation of focal neurologic symptoms or deficits that might require electrodiagnostic studies. Electrodiagnostic studies were recommended for the bilateral upper extremities and audiologic testing was recommended to rule out middle ear trauma. He had bilateral upper extremity complaints specifically weakness of his bilateral hands and fingers and electrodiagnostic testing was recommended to a traumatic neuropathic involvement. On 02/05/14, he saw [REDACTED]

again for headaches and left eye blindness. He had a positive Romberg and positive Tinel's and Phalen's at the wrists. He complained of dizziness, vertigo, and disequilibrium that were worse in the morning and pain and weakness in his bilateral hands and fingers. No other findings were documented and multiple tests were ordered.

IMR ISSUES, DECISIONS AND RATIONALES

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

AUDIOMETRIC TESTING: Upheld

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

Decision rationale: The ODG state audiometry may be "recommended following brain injury or when occupational hearing loss is suspected. Audiometry is a generally accepted and well-established procedure that measures hearing. An audiologist or skilled trained technician administers the test using an audiometer. The machine presents individual frequencies to the patient (typically ranging from 125-8000 Hz) at different levels of loudness (in dBHL). The patient is asked to respond to the sound that he may barely perceive (threshold). Normal thresholds are from 0-25dBHL. The results are displayed in normal graphic form or on audiogram. The audiologist or physician may determine the presence and type (conductive, sensorineural, or mixed) of hearing loss based on the audiogram. Baseline audiometry following brain injury is indicated when the individual with TBI presents with hearing loss, dizziness, tinnitus, or facial nerve dysfunction. Audiograms may be obtained in serial fashion to monitor inner ear function in response to time and treatment. (Mueller, 2005)." In this case, the claimant was injured nearly 8 years ago. There is a brief mention of hearing loss that was evaluated in the past but there is no report of any prior testing for that complaint and there is no indication that hearing loss is being monitored over time. No hearing loss has been documented in the more recent notes. There is also mention of vertigo and dysequilibrium but no focal neurologic deficits, other than a positive Romberg, have been described. The claimant also has a gait problem and a positive Romberg can be related to gait dysfunction. This also has not been addressed. Therefore, the medical necessity of audiometry testing has not been clearly demonstrated.

ELECTROMYOGRAM (EMG) AND NERVE CONDUCTION STUDIES (NCV): Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints.

Decision rationale: The history and documentation do not objectively support the request for bilateral upper extremity EMG/NCV studies at this time. The ACOEM Guidelines states electrodiagnostic studies may be indicated for the evaluation of possible carpal tunnel syndrome. The ACOEM Guidelines, Chapter 8 states regarding Special Studies, "Criteria for ordering imaging studies are: Emergence of a red flag, Physiologic evidence of tissue insult or neurologic dysfunction, Failure to progress in a strengthening program intended to avoid surgery, Clarification of the anatomy prior to an invasive procedure. Physiologic evidence may be in the form of definitive neurologic findings on physical examination, electrodiagnostic studies, laboratory tests, or bone scans. Unequivocal findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging studies if symptoms persist. When the neurologic examination is less clear, however, further physiologic evidence of nerve dysfunction can be obtained before ordering an imaging study. Electromyography (EMG), and nerve conduction velocities (NCV), including H-reflex tests, may help identify subtle focal neurologic dysfunction in patients with neck or arm symptoms, or both, lasting more than three or four weeks." The claimant was injured nearly 8 years ago and he complains of hand pain but no focal neurologic deficits requiring additional evaluation by EMG and NCV have been noted. The claimant had negative Tinel's and Phalen's in November 2013 and then positive Tinel's and Phalen's in February 2014. There is no evidence that this change has been addressed with a conservative course of treatment, including exercise as needed, splinting (if carpal tunnel is suspected), or other treatment methods. There is no evidence of a cervical spine injury with suspected radiculopathy or myelopathy to support a request for an EMG. The medical necessity of these studies has not been clearly demonstrated.