

Case Number:	CM14-0014834		
Date Assigned:	02/28/2014	Date of Injury:	04/26/2006
Decision Date:	07/23/2014	UR Denial Date:	12/17/2013
Priority:	Standard	Application Received:	01/14/2014

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 Neurology, has a subspecialty in Neurocritical care 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 44-year-old male with a 4/26/06 date of injury, when his supervisor severely and violently shook him and threw him backwards about two to three feet, hitting a wall. The patient also injured his head. 10/2/13 Progress note documented difficulty with weight bearing, requiring the use of a cane. The patient experiences 6-8 seizure episodes daily. The patient also has difficulty on memory and concentration. Clinically, there was a persistent right-sided resting/intentional tremor; right hemiparesis; right more than left cranio-cervical spasms; TMJ (Temporomandibular Joint) tenderness; and slightly slurred speech. There was ptosis of the right eye; dysconjugated gaze, left outer gaze; decreased sensation in all 3 branches of the right trigeminal nerve; right facial weakness (central); mild mouth/facial asymmetry; right hypoacusia; right sided tremor, worse at the foot than the hand; and severe right hemiparesis. Sensation was decreased bilaterally at the outer thighs, legs, and plantar surfaces of both feet; reduced sensation at the ventromedial arms, forearms, and hypothenar regions. There was limited range of motion and the patient has balance difficulties. He has not yet been seen by an orthopedic specialist. 9/27/13 orthopedic note documented a request to obtain pertinent medical records as well as a neurological referral. No treatment was recommended for the Achilles tendon. Diagnosis included posttraumatic tremor, cerebral concussion, post-concussive syndrome, probably left brain concussion, rule out other lesion, posttraumatic seizures, TMJ (Temporomandibular Joint) pain, cervical/thoracic/lumbar radiculopathies, cognitive problems, emotional distress, sleep problems, sexual dysfunction, speech dysfunction, and chest pressure. Treatment to date has included activity modification, CPAP (Continuous Positive Airway Pressure), and medication.

IMR ISSUES, DECISIONS AND RATIONALES

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

HOME CARE, 12 HOURS PER DAY FOR 6 MONTHS: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Home Health Services Page(s): 51.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Home Health Services Page(s): 51.

Decision rationale: Medical necessity for home health is not established. CA MTUS states that home health services are recommended only for otherwise recommended medical treatment for patients who are homebound, on a part-time or "intermittent" basis, generally up to no more than 35 hours per week. There is no documentation of necessary medical treatment that would be performed by home health. Housekeeping assistance is not considered medical treatment. Therefore, the request for Home Care, 12 hours per day for 6 months is not medically necessary and appropriate.

LUMBAR EPIDURAL BLOCK INJECTION: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300, Chronic Pain Treatment Guidelines Epidural Steroid Injections (ESIs) Page(s): 46. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: AMA Guides (Radiculopathy).

Decision rationale: The patient has significant health issues, with documentation of 6-8 seizures per day. There are complaints of low back pain, however no documented specific focal neurological deficits. CA MTUS does not support epidural injections in the absence of objective radiculopathy. There are no imaging studies documenting correlating concordant nerve root pathology. Conservative treatment specifically for the low back has not been discussed and a level to be injected has not been specified. There are no electrodiagnostic reports provided. Therefore, the request of Lumbar Epidural Block Injection is not medically necessary and appropriate.

ORTHOPEDIC CONSULTATION: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM, page 127 and ODG Low Back Chapter, Evaluation & Management (E&M).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004), Chapter 7 - Independent Medical Examinations and

Consultations, Clinical Topics, pages 127, 156 and Official Disability Guidelines, Pain Chapter; Office Visit.

Decision rationale: Medical necessity for the requested orthopedic consultation has not been established. CA MTUS states that consultations are recommended, and a health practitioner may refer to other specialists if a diagnosis is uncertain or extremely complex, when psychosocial factors are present or when the plan or course of care may benefit from additional expertise. It has not been documented what conservative treatment has been attempted for orthopedic concerns, including Physical Therapy. There is no imaging of any of the painful body parts. It has not been discussed for which diagnosis the orthopedic consultation is necessary. Therefore, the request for orthopedic consultation is not medically necessary and appropriate.

CONTINUOUS POSITIVE AIRWAY PRESSURE (C-PAP) MACHINE (LATEX FREE):
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-Treatment for Workers' Compensation, Online Edition; HeadChapter (updated 03/22/12); Sleep aids and Other Medical Treatment Guideline or Medical Evidence: Anthem Blue Cross Clinical UM Guideline CG-DME-27.

Decision rationale: This request obtained an adverse determination due to lack of sleep studies. However it was documented that on 2/5/13 the patient was seen for CPAP titration sleep study, and the majority of obstructive offense were controlled. Recommendations were for the patient to use CPAP at 13 cm H2). Proper sleep hygiene, cognitive behavioral therapy, weight loss, and neurology referral were also recommended. Guidelines require objective evidence of sleep apnea before a CPAP machine is found medically necessary. As sleep studies were performed, and CPAP found necessary, the request is substantiated. Therefore, the request for Continuous Positive Airway Pressure (C-PAP) machine (Latex Free) is medically necessary and appropriate.

MRI OF THE THORACIC AND LUMBAR SPINE: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-304. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back (Lumbar & Thoracic) Chapter.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 304. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) ODG (Low Back Chapter) MRI.

Decision rationale: Medical necessity for the requested MRI is not established. With a 2006 date of injury, it is unclear what imaging has been performed, including of the thoracic and lumbar spine. There is note of plain film x-rays; however official imaging reports were not

provided or described. In addition, the patient underwent somatosensory evoked potential testing in 2007, which was normal. CA MTUS criteria for imaging studies include red flag diagnoses where plain film radiographs are negative; unequivocal objective findings that identify specific nerve compromise on the neurologic examination, failure to respond to treatment, and consideration of surgery. In addition, ODG supports thoracic MRI studies in the setting of thoracic spine trauma with neurological deficit. There are no documented focal neurological deficits to indicate necessity for MRI, or a discussion regarding the need for surgical treatment of either the thoracic or lumbar spine. As such, the request of MRI of the thoracic and lumbar spine is not medically necessary and appropriate.

BALANCE REHABILITATION: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Head chapter; Vestibular Physical Therapy rehabilitation and (<http://www.brainline.org/cotent/2011/02/what-is-balance-andvestibular-rehabilitation-therapy.html>).

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; Vestibular Physical Therapy rehabilitation.

Decision rationale: Although the patient was noted to have balance difficulties, there's no further description of any specific vestibular dysfunction. Prior to undergoing rehabilitation, in-depth assessment is necessary. ODG states that vestibular physical therapy has been established as the most important treatment modality for this group of patients, however without clear documentation of specific vestibular disorder, other than "dizziness," vestibular therapy cannot be recommended. Furthermore, there was a recommendation for a neurological referral, however no such evaluation was documented. Therefore, the request for Balance Rehabilitation is not medically necessary and appropriate.

AQUA THERAPY 3 TIMES PER WEEK FOR 4 WEEKS: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Aqua Therapy.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 22.

Decision rationale: Medical necessity for the requested aquatic therapy is not established. Although it is noted that the patient is overweight, BMI was not documented. CA MTUS states that aquatic therapy is recommended as an optional form of exercise therapy, where available, as an alternative to land-based physical therapy when reduced weight bearing is indicated, such as with extreme obesity. Although it is clear that the patient has functional deficits, it has not been discussed why the patient is unable to perform land-based physical therapy. As such the request for Aqua Therapy 3 times per week for 4 weeks is not medically necessary and appropriate.

PSYCHOLOGICAL EVALUATION (INCLUDING COGNITIVE TESTING AND ANATOMICAL): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Psychological Evaluations.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Psychological evaluations Page(s): 100-101.

Decision rationale: Medical necessity for the requested psychological evaluation is not established. This request obtained an adverse certification as the 10/2/13 medical report documented that a psych consult was approved and pending. There remains no discussion of why additional certification is necessary, or the period of certification has lapsed. Therefore, the request for Psychological Evaluation (including cognitive testing and anatomical) is not medically necessary and appropriate.

FUNCTIONAL CAPACITY EVALUATION: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines FUNCTIONAL RESTORATION PROGRAMS (FRPS).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Chapter 7 Independent Medical Examinations and Consultations (page 132-139); Official Disability Guidelines (ODG).

Decision rationale: Medical necessity for the requested FCE (Functional Capacity Evaluation) is not established. Generally CA MTUS recommends FCE (Functional Capacity Evaluation) when the patient has had prior unsuccessful return to work attempts and there are injuries that require detailed exploration of a worker's abilities. While sequela from the patient's injury is significant, very little has been discussed regarding the patient's work status since the 2006 injury. Guidelines state that timing is very important, and the patient should be close to or at MMI (Maximum Medical Improvement). Medical records indicate that the patient has significant limitations, including with self-care. Utility of FCE at this time is not entirely clear. Therefore, the request for Functional Capacity Evaluation is not medically necessary and appropriate.

TRIGGER POINT INJECTIONS WITH SEDATION: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TRIGGER POINT INJECTIONS.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 122.

Decision rationale: The patient has complaints of pain in the neck, thoracic spine, and low back, as well as other body parts; however there's no documentation of circumscribed trigger points with a twitch response, which is required by CA MTUS chronic pain guidelines. Without

documentation of myofascial pain syndrome and trigger points found on physical examination, guidelines do not support trigger point injections. In addition, the patient is diagnosed with radiculopathy, and lumbar ESI had been suggested, however deferred at this time. Trigger point injections are generally not recommended in patients with radiculopathy. As such the request for Trigger Point Injections with sedation is not medically necessary and appropriate.

TWO (2) TRANSDERMAL COMPOUNDS: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 112-113.

Decision rationale: Medical necessity for the requested transdermal compounds is not established. Medical records did not describe components of this topical medication. CA MTUS Chronic Pain Medical Treatment Guidelines state that ketoprofen, lidocaine (in creams, lotion or gels), capsaicin in a 0.0375% formulation, baclofen and other muscle relaxants, and gabapentin and other antiepilepsy drugs are not recommended for topical applications. In addition, any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Without specific description of the agents included within this compound medication, the request cannot be substantiated. Therefore, the request for two (2) transdermal compounds is not medically necessary and appropriate.