

Case Number:	CM14-0017424		
Date Assigned:	07/07/2014	Date of Injury:	01/31/2012
Decision Date:	08/07/2014	UR Denial Date:	01/15/2014
Priority:	Standard	Application Received:	02/11/2014

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:

Injured worker is a female with date of injury 1/31/2012. Per neurology new patient consult note dated 9/24/2013, the injured worker was referred with the diagnoses of PTSD and severe headaches that occurred from a work related injury that occurred on 1/31/2012. Since her injury she has suffered from pain in the neck and head and impaired vision in the right eye. She stated that the vision of the right eye is obscured by a large dark dot and that the objects in the visual field of the right eye appear smaller than they should. Headaches occur at no particular time of the day and begin with increased neck pain. She has no warning that a headache will occur except for increased neck pain. The headaches occur daily and are not associated with any of the deficits other than nausea without vomiting. Headaches throb when they are severe. She has constant pain in the neck. She has lost hearing in the right ear, but there are times when things sound louder than she expects. Pain in the neck radiates to the shoulders. She has feelings of worms crawling along the right head. She has sensation of vibration in both shoulder areas. She has had problems with hand eye coordination. Low back pain has been present since her injury. If she presses certain areas in her low back, heat travels from the buttocks to the lateral thighs, legs and feet. Since her injury occurred, she has been depressed, anxious and fearful. On examination her pupils were unreactive to light and accommodation at 3 mm on the right and 2 mm on the left. Ptosis was bilateral and slight. She had a dimple in the center of the chin about which occasional fasciculation's occurred. Cervical lordosis was straightened and the range of motion was limited. There was spasm of the neck and right SCM with pain to palpation of the paraspinal muscles and trapezius areas. The carotid pulses were decreased. The right lobe of the thyroid was enlarged. There was a 2/6 systolic murmur, heard best at the left lower and right upper sternal borders. Peripheral pulses were decreased. Abdominal reflexes were absent. Range of motion of the right shoulder was limited in all planes and painful, and crepitus was present.

The back range of motion was decreased with slight pain. Right central facial weakness was present. There was no glabellar response and jaw jerk reflex was not present. There was torticollis with the chin turning leftward. The muscle tone was increased on the right. Bulk was reduced in the right arm, right forearm and left calf. RAMs were slowed on the right. Muscle spasm was present in the neck and thoracic spine. Reflexes were trace at the right biceps, 0 at the left biceps, 2+ at the right triceps, 1+ at the left triceps, 1+ at the right knee, trace at the left knee, 0 at the right ankle, and 1+ at the left ankle. There coarse, bilateral tremors with dysmetria. She could do a tandem walk with difficulty and tended to list to the left. Gait and station were wide-based and antalgic. Light touch and pinprick were decreased in the right arm, face, torso and leg as well as along the right ulnar forearm. MMSE was 23/29 with the patient making two mistakes with serial calculations, disorientation to place, inability to read and not being able to follow serial commands. Diagnoses include: 1) status post closed head injury with concussion, 2) post traumatic migraines 3) radicular neck pain with toticollis and chronic pain, 4) radicular back pain and strain, 5) right sensory neural hearing loss secondary to traumatic brain injury, 6) cerebellar ataxis and tremors, presumably from traumatic brain injury, 7) signs consistent with lacunar left brain injury vs. effects of traumatic brain injury, 8) right shoulder disruption, 9) phenotypic risk for obstructive sleep apnea, 10) right thyroid enlargement, non-industrial, 11) peripheral vascular disease, 12) heart murmur, 13) complaints of becoming disoriented outside the home, rule out seizure, 14) unreactive pupils to light and minimally reactive pupils to accommodations, rule out Argyl-Robertson pupil defects from non-industrial causes vs. effects of traumatic brain injury, 15) PTSD, depression, anxiety.

IMR ISSUES, DECISIONS AND RATIONALES

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

24 hour ambulatory EEG for the brain: 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 (ODG), Head chapter, EEG (neurofeedback) section.

Decision rationale: Per the requesting physician, the injured worker has had events of altered mental status outside of her home during and following which she has become disoriented to place. Epilepsy secondary to TBI should be ruled out. The brain injury should be evaluated, to include a 24 hour ambulatory EEG. The claims administrator does not explain why this request was not medically necessary. The MTUS Guidelines do not address the use of EEG. The ODG recommends the use of EEG if there is failure to improve or additional deterioration following initial assessment and stabilization. The EEG may aid in diagnostic evaluation. The requesting physician is a neurologist who has been consulted 20 months following the injury. The EEG is not being utilized acutely. The requesting physician clearly states that the injured worker is status post traumatic brain injury, and that there is concern for possible seizures as the injured worker describes periodic moments of altered mental status. There is a concern of epilepsy secondary to

TBI. The request for 24 hour ambulatory EEG for the brain is determined to be medically necessary.