MAXIMUS Federal Services

Case Number:	CM14-0130897		
Date Assigned:	08/20/2014	Date of Injury:	06/12/1999
Decision Date:	09/24/2014	UR Denial Date:	08/12/2014
Priority:	Standard	Application Received:	08/15/2014

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 Pain Medicine and is licensed to practice in Florida. 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:

7/31/14 note indicates headaches that start on left and can be bifrontal. There are daily headaches that last 1-2 hours. Examination notes normal cranial nerves, muscle exam, reflexes, coordination, gait and station. 5/22/14 note indicates a 5/22/14 MRA demonstrates a right supraclinoid internal carotid artery aneurysm that is 2 by 9 mm and a width of 9mm.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 Neurosurgeon Consultation: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines pain Page(s): 305-306.

Decision rationale: The medical records provided for review indicate the presence of a vascular aneurysm of the carotid artery that is of a size (greater than 5 mm) to raise concern for potential rupture. MTUS supports referral to specialist for evaluation and surgical consideration for treatment.

1 Cerebral Angiogram: 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 Recommended as indicated below. CT scans are noninvasive and should reveal the presence of blood, skull fracture, and/or structural changes in the brain. CT scans provide limited information about intrinsic cerebral damage involving deep brain structures. CT scans are widely accepted for acute diagnostic purposes, and for planning acute treatment. They are the screening image of choice in acute brain injury and are used to assess the need for neurosurgical intervention. (Colorado, 2005) (ACEP, 2002) (Brain, 2003) (Brain, 2000) (East, 2000) (Englander, 2003) (Krotz, 2004) (National, 2003) (Stiell, 2001) Neuroimaging is not recommended in patients who sustained a concussion/mTBI beyond the emergency phase (72 hours post-injury) except if the condition deteriorates or red flags are noted. (Cifu, 2009) Primary care physicians are making a significant amount of inappropriate referrals for computed tomography (CT) and magnetic resonance imaging (MRI) studies, according to new research published in the Journal of the American College of Radiology. The study found that 74% of examinations were considered appropriate, and 26% were not. Examples of inappropriate examinations included the following: Head CT for chronic headache; Lumbar spine MRI for acute back pain without conservative therapy; Knee or shoulder MRI in patients with no histories of trauma and documented osteoarthritis on plain-film radiography. CT examinations of the brain without contrast had the highest percentage of inappropriate examinations: 62% of total head CTs. These were performed primarily for nonacute symptoms with no neurologic findings. In addition, there were high rates of inappropriate examinations for spinal CTs (53%), and for spinal and shoulder MRIs (35% and 37%, respectively). (Lehnert, 2010)Indications for computed tomography :- CT scans are recommended for abnormal mental status, focal neurologic deficits, or acute seizure and should also be considered in the following situations:- Signs of basilar skull fracture- Physical evidence of trauma above the clavicles- Acute traumatic seizure- Age greater than 60- An interval of disturbed consciousness- Pre-or post-event amnesia- Drug or alcohol intoxication- Any recent history of TBI, including MTBI- Also may be used to follow identified pathology or screen for late pathology. Subsequently, CT scans are generally accepted when there is suspected intracranial blood, extra-axial blood, hydrocephalus, altered mental states, or a change in clinical condition, including development of new neurological symptoms or post-traumatic seizure (within the first days following trauma). MRI scans are generally recommended as opposed to CT once the initial acute stage has passed. (Colorado, 2005)- Patients presenting to the emergency department with headache and abnormal findings in.

Decision rationale: The medical records provided for review indicate 1 diagnostic radiology test with abnormal findings. The records do not demonstrate any additional information that will be added by additional imaging study and does not indicate requirement of a surgeon to have the test for diagnostic or surgical planning.