Case Number:	CM14-0132210		
Date Assigned:	08/22/2014	**Date of Injury:**	05/25/1996
Decision Date:	10/02/2014	**UR Denial Date:**	08/11/2014
Priority:	Standard	**Application Received:**	08/18/2014

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 Physical Medicine and Rehabilitation 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 injured worker is an 85-year-old female who reported an injury on 05/25/1996 while working in a kitchen area picking up an order, she slipped and fell on some spilled noodles on the floor. She sustained injuries to the head, neck, arms, lower back, and knees. Diagnoses were status post fall with multiple injuries and concussion, post-traumatic head syndrome, post-traumatic vertigo. Past treatments were medications and physical therapy. Diagnostic studies were not reported. Surgical history included hysterectomy and left knee arthroscopic surgery. Physical examination on 08/06/2014 revealed complaints of headaches and knee pain. Headaches were located about the top of the head, characterized on a pain scale as a 5/10. The injured worker described dizziness, vertigo, blurred vision, nausea, memory problems, ringing in the ears, loss of balance, depression, anxiety, sleep difficulty, and sensitivity to light and sound. The injured worker also reported an intermittent bilateral upper extremity pain associated with numbness, tingling, weakness, grip loss, and spasms. There were complaints of upper back pain, associated with stiffness and spasms. There were complaints of lower extremity pain, associated with numbness, tingling, weakness, coldness, tripping, spasms, and falling. The injured worker reported that she fell at home about 2 months ago and may have had a brief loss of consciousness. It was also reported that the injured worker had a stroke about 4 years prior. The injured worker reported the headaches began sometime in 2013. Examination for mental status revealed brief assessment of recent memory and immediate recall revealed some difficulty. The injured worker was able to recall 1 out of 3 objects in 5 minutes. Attention span appeared to be poor. The injured worker answered 4 out 5 Serial Sevens. Speech was fluent. Comprehension, repetition, and naming was normal. Cranial nerve examination revealed visual fields were full to confrontation. Facial pinprick and light touch sensation was intact, and motor 5 intact. Symmetrical facial musculature with grimace. Acuity to finger rub was decreased bilaterally.

Hallpike maneuver was positive with nystagmus. Motor examination revealed weakness of the right shoulder with abduction and flexion. Coordination testing revealed normal finger to nose and heel to shin testing. Rapid alternating movements were normal bilaterally. Romberg was negative. Deep tendon reflexes were 1 to 2+. There was decreased sensation to pinprick about the right arm. Medications were Meclizine 12.5 mg 3 times a day as needed for dizziness. Treatment plan was for home health care, MRI of the cervical spine, MRI of the lumbar spine, MRI of the head, and transportation to doctor's appointments. The rationale was not submitted. The Request for Authorization was submitted.

IMR ISSUES, DECISIONS AND RATIONALES

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

Home Health Care, 7 Days A Week/ 4 Hrs A Day: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Home Health Services.

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

Decision rationale: The Official Disability Guidelines for home health services state it is only for otherwise recommended medical treatment for patients who are home bound, on a part time or intermittent basis, generally up to no more than 35 hours per week. Medical treatment does not include homemaker services like shopping, cleaning, laundry, and personal care given by home health aides like bathing, dressing, and using the bathroom when this is the only care needed. The rationale for why the injured worker needed home health services was not reported. It was not reported that the injured worker was homebound or handicapped. The injured worker had a physical examination on 07/23/2014 with her primary care physician, and it was reported that she had slight improvement since the last visit. It was not reported in that visit why the injured worker needed home health care 7 days a week for 4 hours a day. Therefore, the request for home health care, seven days a week for four hours a day is not medically necessary and appropriate.

MRI - Cervical Spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 182.

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

Decision rationale: 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 physiologic evidence indicates tissue insult or nerve impairment, consider a discussion with a consultant regarding next steps, including the selection of an imaging test to define a potential cause (magnetic resonance imaging [MRI] for neural or other soft tissue, compute tomography [CT] for bony structures). Additional studies may be considered to further define problem areas. The recent evidence indicates cervical disk annular tears may be missed on MRIs In the following circumstances, an imaging study may be appropriate for a patient whose limitations due to consistent symptoms have persisted for four to six weeks or more only if surgery is being considered for a specific anatomic defect or to further evaluate the possibility of potentially serious pathology, such as a tumor. In this case, the injured worker reported on physical examination dated 07/23/2014 that pain in the neck was aggravated when she tilts her head up and down or moves side to side. There were no diagnostic studies such as x-rays reported. Physical therapy was not reported. Medication reported was meclizine. Therefore, the request for a MRI of the cervical spine is not medically necessary and appropriate.

MRI - Head: 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), Treatment Index, 12 Edition (web) , 2014, Head, MRI

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines Head, MRI (Magnetic Resonance Imaging)

Decision rationale: The Official Disability Guidelines for magnetic resonance imaging is a well established brain imaging study in which the individual is positioned in a magnetic field and a radiofrequency pulse is applied. Normal tissues give off 1 signal, while abnormal structures give off a different signal. Due to its high contrast resolution, MRI scans are superior to CT scans for the detection of some intracranial pathology, except for bone injuries such as fractures. MRI may reveal an increased amount of pathology as compared with CT. Specific MRI sequences and techniques are very sensitive for detecting traumatic cerebral injury; they may include, but are not limited to, diffusion tensor, gradient echo, and fluid attenuated inversion recovery. Some of these techniques are not available on an emergency basis. Neuro imaging is not recommended in patients who sustained a concussion/mild traumatic brain injury beyond the emergency phase (72 hours post injury) except if the condition deteriorates or red flags are noted. Indications for MRI are to determine neurological deficits not explained by a CT, to evaluate prolonged interval of disturbed consciousness, to define evidence of acute changes super imposed on previous trauma or disease. The injured worker sustained a concussion when she fell. The medical guidelines state it is not recommended in patients who sustained a concussion/mild traumatic brain injury beyond the emergency phase of 72 hours post injury. The injured worker is not displaying any red flags. Therefore, the request for a MRI of the head is not medically necessary.

MRI- Lumbar Spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 309.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-305.

Decision rationale: The California ACOEM Guidelines state unequivocal objective findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging in patients who do not respond to treatment and who would consider surgery an option. When the neurologic examination is less clear, however, further physiologic evidence of nerve dysfunction should be obtained before ordering an imaging study. If physiologic evidence indicates tissue insult or nerve impairment, the practicioner can discuss with a consultant the selection of an imaging test to define a potential cause (magnetic resonance imaging (MRI), for neural or other soft tissue, computer tomography (CT) for bony structures). Relying solely on imaging studies to evaluate the source of low back and related symptoms carries a significant risk of diagnostic confusion (false positive test results) because of the possibility of identifying a finding that was present before symptoms began and, therefore, has no temporal association with the symptoms. Imaging studies should be reserved for cases in which surgery is considered or red flag diagnoses are being evaluated. Because the overall false positive rate is 30% for imaging studies in patients over age 30 who do not have symptoms, the risk of diagnostic confusion is great. Physical examination on 07/23/2014 of the lower back revealed the injured worker had numbness and tingling in her left leg. This does not indicate the need for imaging studies. This examination is lacking information. A more thorough examination of the lower spine is needed. The injured worker did not have any red flags. Therefore, the request for a MRI of the lumbar spine is not medically necessary and appropriate.