

Case Number:	CM14-0133164		
Date Assigned:	08/22/2014	Date of Injury:	01/08/2014
Decision Date:	11/19/2014	UR Denial Date:	07/28/2014
Priority:	Standard	Application Received:	08/20/2014

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 Anesthesiology, 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:

The injured worker is a 38-year-old male who reported injury on 01/08/2014. The injured worker was involved in a motor vehicle accident, when a truck collided with the injured worker's patrol car and flipped. The injured worker has significant hypertension and chronic back pain. Prior treatment history included physical therapy with benefit, medications, trigger point injections with ultrasound guidance on 04/16/2014 with significant improvement, but temporary relief. Diagnostic studies included x-ray of the lumbar spine dated 3/06/2014 that revealed hypermobility of the facet joint at the L5-S1 level with foraminal stenosis; on the anterior/posterior view there was significant rotation of the L4 on L5 level with slight step off at the right side of the back compared to the left where it lines up. On 07/09/2014, the injured worker presented with cervical pain, upper extremity pain, headache and imbalance. On physical examination of the head and neck, posterior as well as shoulder, documented no erythema, ecchymosis or edema. There was no tenderness, crepitation or deformity to palpation. There was a neutral position of the neck and head. The movement was mildly restricted in all the directions. There was normal stability, strength and tone. The muscle strength, tone and atrophy of the bilateral extremities examination revealed muscle strength of major group was 5/5. There was a normal tone of major group and muscle bulk. There was no fasciculations. The right upper extremity revealed generalized moderate tenderness over the shoulder girdle. There was no crepitation. There were positive twitching responses on the right upper trapezius, cervicobrachial. The deep tendon reflexes were normal and symmetrical. The cranial nerve examination revealed II -XII were intact. The treatment plan consisted of head impulse testing with "VBW", medications, continue physical therapy for 8 more sessions and appeal denial for the vestibular assessment and rehabilitation and followup in 2 months. The diagnoses included

headache post-traumatic, migraine, myofascial pain with trigger points and rule out vestibular dysfunction.

IMR ISSUES, DECISIONS AND RATIONALES

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

Head impulse testing: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Head, Vestibular Studies.

Decision rationale: The injured worker is a 38-year-old male who reported injury on 01/08/2014. The injured worker was involved in a motor vehicle accident, when a truck collided with the injured worker's patrol car and flipped. The injured worker has significant hypertension and chronic back pain. Prior treatment history included physical therapy with benefit, medications, trigger point injections with ultrasound guidance on 04/16/2014 with significant improvement, but temporary relief. Diagnostic studies included x-ray of the lumbar spine dated 3/06/2014 that revealed hypermobility of the facet joint at the L5-S1 level with foraminal stenosis; on the anterior/posterior view there was significant rotation of the L4 on L5 level with slight step off at the right side of the back compared to the left where it lines up. On 07/09/2014, the injured worker presented with cervical pain, upper extremity pain, headache and imbalance. On physical examination of the head and neck, posterior as well as shoulder, documented no erythema, ecchymosis or edema. There was no tenderness, crepitation or deformity to palpation. There was a neutral position of the neck and head. The movement was mildly restricted in all the directions. There was normal stability, strength and tone. The muscle strength, tone and atrophy of the bilateral extremities examination revealed muscle strength of major group was 5/5. There was a normal tone of major group and muscle bulk. There was no fasciculations. The right upper extremity revealed generalized moderate tenderness over the shoulder girdle. There was no crepitation. There were positive twitching responses on the right upper trapezius, cervicobrachial. The deep tendon reflexes were normal and symmetrical. The cranial nerve examination revealed II -XII were intact. The treatment plan consisted of head impulse testing with "VBW", medications, continue physical therapy for 8 more sessions and appeal denial for the vestibular assessment and rehabilitation and followup in 2 months. The diagnoses included headache post-traumatic, migraine, myofascial pain with trigger points and rule out vestibular dysfunction.