

Case Number:	CM14-0167647		
Date Assigned:	10/14/2014	Date of Injury:	09/02/2009
Decision Date:	11/20/2014	UR Denial Date:	09/26/2014
Priority:	Standard	Application Received:	10/10/2014

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 General Surgery, has a subspecialty in Colon and Rectal Surgery 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 a 38-year-old male who reported an injury on 02/09/2009 while working as a roofer, the scaffolding moved under the ladder he was standing on and he fell approximately 9 to 18 feet, striking his head and hitting the right side of his face and head on a fence. Diagnoses were post-concussion syndrome with cognitive deficits and frequent tinnitus, post-concussion headaches/migraines, status post multiple cranial and facial fractures with apparent right temporomandibular joint syndrome, chronic cervicalgia, chronic back pain, rule out bilateral cervical radiculitis, sciatica, rule out bilateral lumbosacral radiculitis with motor findings on the right at L4 and L5, lumbar degenerative disc disease and spondylolisthesis, per MRI, right shoulder impingement syndrome, apparent fall risk due to ambulatory deficits, pain related insomnia, pain in situational depression, anxiety, suicidal ideation, and posttraumatic visual disturbance involving right eye. The injured worker had an MRI of the brain on 10/24/2013 that revealed enhancing vessels in the left posterior ventral lobe, periventricular white matter that extended down through the left caudate nucleus, likely to the wall of the left frontal horn on the lateral ventricle. There was no mass effect and it is suspected this is an incidental benign venous angioma. There are numerous small foci of abnormal T2 hyper intensity in the subcortical and periventricular white matter of both frontal lobes. These foci were nonspecific but were considered abnormal in a patient of this age. The injured worker has had difficulties with anal fissures since 01/2014. The injured worker underwent Botox A injections of his rectum on 07/22/2014 that reduced the pain and bleeding. It appeared that the injections have been helping with the healing of the injured worker's anal fissure. The injured worker also has a history of chronic migraine as well as stabbing headaches. Physical examination dated 09/12/2014 revealed that the injured worker continued to note chronic headaches, as well as chronic pain of the right shoulder and neck and back, with radicular symptoms to the bilateral

upper and lower extremities. The injured worker continued to note associated cognitive deficits. Examination of the head and neck revealed a loud crack can be heard when the patient's jaw with attempted full opening of the mouth. There was on slurring of the speech noted. There was some intermittent lateral nystagmus noted on extraocular movement testing. Medications were Norco 10/325 mg 1 every 4 hours as needed, Senna, Colace 250 mg 1 twice a day, Wellbutrin SR 150 mg 1 twice a day, Geodon 40 mg 1 twice a day, Topamax 100 mg 1 twice a day, Lexapro 20 mg 1 every day, Metformin 500 mg 1 twice a day, Glucotrol, and Lovastatin. The treatment plan was for 6 additional neuropsychological follow-up appointments. The rationale was "I am resubmitting the request for skilled nursing for 3 hours a day for 3 months, and I am requesting 12 weeks of cognitive skills training with [REDACTED] at 10 hours per week. It should be noted that home health assistance cannot provide all of the care that the patient requires as he has had a brain injury and his cognitive and physical deficits are considerable. Deprivation of these services will result, as mentioned by [REDACTED] in a severe decline in his psychological status. The patient has been prone to psychological crisis previously and his tendency toward depression is considerable." The request for authorization was not submitted.

IMR ISSUES, DECISIONS AND RATIONALES

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

Six (6) additional monthly neuropsychological follow up appointments: 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, Neuropsychological Testing

Decision rationale: The decision for six (6) additional monthly neuropsychological follow-up appointments is medically necessary. The Official Disability Guidelines state that neuropsychological testing is recommended for severe traumatic brain injury, but not for concussions unless symptoms persist beyond 30 days. For concussion/mild traumatic brain injury, comprehensive neuropsychological/cognitive testing is not recommended during the first 30 days post injury, but should symptoms persist beyond 30 days, testing would be appropriate. Attention, memory, and executive functioning deficits after traumatic brain injury can be improved using interventions emphasizing strategy training (i.e., training patients to compensate for residual deficits, rather than attempting to eliminate the underlying neurocognitive impairment) including use of assistive technology or memory aids. Neuropsychological testing is one of the corner stones of concussion and traumatic brain injury evaluation and contributes significantly to both understanding of the injury and management of the individual. It was reported that when the injured worker is in a structured program with executive intervention, he is stable and more functional to participate in his own complicated medical and self-care. When the structure has faded and is unavailable to the injured worker, he deteriorates into a hopeless, isolating depression that is unable to participate in decisions regarding his life or his medical care. The injured worker had an MRI on 10/24/2013 that revealed numerous small foci of abnormal T2 hyper intensity in the subcortical and periventricular white matter of both frontal

lobes. It was reported that these foci are nonspecific that are considered abnormal in a patient of this age. It was also reported that the injured worker had dizziness and vision changes. The injured worker has a history of psychiatric crisis; the last one was in 01/2013, in which he experienced suicidal ideation, along with visual and auditory hallucinations. He was admitted to a psychiatric ward. The clinical documentation submitted for review does provide evidence that the injured worker needs 6 additional monthly neuropsychological follow-up appointments. Therefore, this request is medically necessary.

One (1) office follow up appointment with colorectal surgeon: 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 Part 1: Introduction Page(s): 1.

Decision rationale: The decision for one (1) office follow-up appointment with colorectal surgeon is medically necessary. The California Medical Treatment Utilization Schedule states the physician begins with an assessment of the presenting complaint and a determination as to whether there is a "red flag for a potentially serious condition" which would trigger an immediate intervention. Upon ruling out a potentially serious condition, conservative management is provided. If the complaint persists, the physician needs to reconsider the diagnosis and decide whether a specialist's evaluation is necessary. If the patient continues to have pain that persists beyond the anticipated time of healing, without plans for curative treatment, such as surgical options, the Chronic Pain Medical Treatment Guidelines apply. This provides a framework to manage all chronic pain conditions, even when the injury is not addressed in the clinical topic section of the MTUS. The clinical documentation submitted for review provides evidence that the injured worker has had an anal fissure since 01/2014. The injured worker was placed on Colace and Senna to help with the constipation. The injured worker did report some relief of the constipation. The injured worker underwent Botox A injections of his rectum on 07/22/2014 that helped reduce pain and reduce the bleeding. It was reported that the injections had helped with the healing of the anal fissure. It was also noted that the anal fissure had not completely healed. The medical guidelines state that if the complaint persists, the physician needs to reconsider the diagnosis and decide whether a specialist evaluation is necessary. The clinical documentation submitted for review does provide evidence that the injured worker is in need of 1 office follow-up appointment with colorectal surgeon. Therefore, this request is medically necessary.