

<b>Case Number:</b>	CM14-0038088		
<b>Date Assigned:</b>	06/25/2014	<b>Date of Injury:</b>	10/28/2011
<b>Decision Date:</b>	11/26/2014	<b>UR Denial Date:</b>	03/13/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/01/2014

### 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, and is licensed to practice in Texas. 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 46-year-old male who reported injury on 10/28/2011. The mechanism of injury was the injured worker was hit in the back of his head or fell on the back of his head. The injured worker was noted to be the victim of assault however did not remember anything before or after the assault. The injured worker was noted to have suffered a skull fracture and subdural hematoma. The injured worker underwent speech therapy, vision therapy, physical therapy, and occupational therapy. The surgical history was not provided. The medications included Cymbalta 60 mg per day, Lamictal 200 mg per day, Seroquel 50 mg at night, Indocin 25 mg 3 times daily, Humatrope 0.25 mg per day, Microzide 62.5 mg per day, Lisinopril 10 mg 1 per day, Lidocaine patches 1 per day, and Vicodin as needed. There was no request for authorization submitted for review for the requested procedure. The documentation of 02/14/2014 revealed the injured worker had intermittent epistaxis since the head injury in 2011. The injured worker had primarily left sided epistaxis lasting 5 to 10 minutes. The injured worker had been getting bleeding from the right side. The injured worker was not on aspirin or blood thinners and had no other bleeding issues. The physical examination revealed the sinuses were nontender and there was no swelling or overlying redness. The external nasal exam was within normal limits. The septum was moderately deviated to the right and mucous membranes were without blood or crusting on the left. On the right there was fresh blood in the anterior septum. This was gently cleaned with a Q-tip soaked with Xylocaine and a bleeding site was identified on the superior anterior septum. Silver nitrate was applied and the bleeding stopped. The injured worker was able to blow his nose vigorously and had no additional bleeding noted. The turbinates were normal. There were no polyps. The diagnosis was epistaxis secondary to dryness and deviated nasal septum and the recommendation was for daily nasal ointment to prevent dryness and bleeding. The subsequent documentation of 02/24/2014 revealed the injured worker had no

significant nosebleeds since the cauterization; however, the injured worker complained of nasal congestion and increased snoring. The physical examination revealed the sinuses were nontender and there was no swelling or overlying redness. The external nasal examination was normal. The septum was moderately deviated to the right there was a scab at the cautery site but no evidence of fresh blood. The injured worker blew his nose; however, it did not help with nasal congestion. Lateral traction on the cheek improved breathing markedly. The turbinates were normal; there were no polyps seen. The treatment plan included a referral for surgical correction of an acquired nasal deformity. The diagnostic studies included a CT scan which revealed a tiny mucous retention cyst. There was no Request for Authorization submitted to support the request.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**Surgery: Septoplasty turbinectomy, valve repair, septal cartilage graft:** 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), Head Chapter, Septoplasty

**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, Septoplasty

**Decision rationale:** The Official Disability Guidelines indicate that for a Septoplasty it is recommended to correct an anatomic deformity or deviation of the nasal septum and may be performed in response to an injury. There should be documentation of 1 or more of the following: nasal airway obstruction or difficulty breathing causing any of the following: mouth breathing, snoring, sleep apnea, or recurrent sinus infections, frequent nosebleeds, atypical fascial pain of nasal origin, positive response to topical anesthetic or deformed septum context turbinate, or asymptomatic deformity that prevents surgical access to other intranasal areas. All of the following are required: A complete anterior and posterior nasal exam, the absence of documentation of the absence of nasal polyps, tumors, turbinate hypertrophy or other causes of obstruction unless a removal is part of the proposed surgery, identification of known or suspected bleeding site if the proposed surgery is to control epistaxis, identification of sinus that is recurrently infected if the purpose of surgery is to control disease, and description of nasopharynx, oropharynx, hypopharynx and larynx if proposed surgery is to prevent sleep apnea or snoring. The clinical documentation submitted for review indicated the injured worker had nasal bleeding that was controlled. There was a lack of documentation indicating the injured worker had difficult nasal breathing causing mouth breathing, snoring, sleep apnea, or recurrent sinus infections. There was a lack of documentation indicating the injured worker had turbinate hypertrophy or had recurrent epistaxis as the turbinates were noted to be normal. There was a lack of documentation indicating the injured worker had recurrent sinus infections. Given the above, the request for Septoplasty turbinectomy, valve repair, and septal cartilage graft is not medically necessary.