

Case Number:	CM14-0042830		
Date Assigned:	06/30/2014	Date of Injury:	10/15/2005
Decision Date:	07/30/2014	UR Denial Date:	03/13/2014
Priority:	Standard	Application Received:	04/09/2014

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, has a subspecialty in Interventional Spine 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 patient is a 62-year-old male with date of injury of 10/15/2005. The listed diagnoses dated 02/03/2014 are: 1. Mild epistaxis (nosebleeds), probably secondary to deconditioning from Plavix. 2. Bilateral hearing nerve loss. 3. Tinnitus. 4. Vertigo/dizziness. 5. History of post-concussive injury, 2005. 6. History of post-traumatic stress disorder, 2005. 7. Hypertensive cardiovascular disease, status post hypertensive CVA March 2013 with right hemiplegia. 8. Acute right Bell's palsy., and 9. Two liver masses, rule out liver malignant masses. According to this report, the patient was sent for evaluation for his frequent nosebleeds. At that time, the physician took him off all of his medications which included Plavix, baby aspirin, and his blood pressure medicine, atenolol. The patient notes he has had tinnitus since his injury in 2005. He also states that he has had some issues with hearing loss secondary to Bell's palsy that started in 2010 with episodes of dizziness since he had a stroke in March 2013. The physical exam of the right ear shows no evidence of pathology or deformity. The tympanic membrane is intact and translucent without any signs of inflammation or perforation. His nasal pyramid is straight without any evidence of deformity or pathology. There is no obstruction on either nasal passageway and the nasal septum is centered in the mid line. The airflow on either side appears to be adequate. No sinus tenderness was noted with palpation. There are no bony deformities in the face. The malar eminences appear equal in size and full. There is no evidence of malocclusion. Sensory function of the facial nerves appears to be proper. The mandible occludes well up to the maxilla. The utilization review denied the request on 03/13/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Post Cerebrovascular accident (CVA) Physical Therapy 3 times a week for 8 weeks:
Overturned

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, Physical Medicine Treatment; Knee & Leg, Physical Medicine Treatment.

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

Decision rationale: This patient presents with frequent nosebleeds and ringing in the ears. The treater is requesting 16 post-CVA physical therapy. The patient is status post CVA from March 2013. The MTUS and ACOEM Guidelines do not address this request; however, ODG Guidelines recommends 20-40 visits over 4 weeks for Hemaplegia and Hemiparesis. The utilization review modified the request to 12 physical therapies and references that the patient completed 12 physical therapy visits to date. The handwritten physical therapy report dated 01/22/2014 showed that the patient has increased foot clearance and stability as well as increased velocity. The patient has had a right foot drop since the onset of the CVA. The 01/31/2014 report notes that the patient continues with hemiplegia and right footdrop. There is some improvement with his facial palsy. The Letter of Medical Necessity by [REDACTED] dated 03/05/2014 documents that the patient continues to need gait training and balance coordination for mobility and safety. In this case, the patient continues to exhibit mobility issues. And the requested 16 visits, when combined with the previous 12, are within ODG Guidelines. Recommendation is for authorization.