

Case Number:	CM14-0188450		
Date Assigned:	11/19/2014	Date of Injury:	02/15/1998
Decision Date:	01/07/2015	UR Denial Date:	10/31/2014
Priority:	Standard	Application Received:	11/12/2014

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 Preventive Medicine, has a subspecialty in Occupational Medicine and is licensed to practice in Iowa. 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:

This is a 57 year old injured worker with date of injury of 02/15/1998. Medical records indicate the injured worker is undergoing treatment for depression, difficulty swallowing, hoarseness, laryngeal candidiasis, lower back pain, oral thrush, vallecular cyst, status post discectomy, laminectomy, posterior and anterior fusion, lumbar radiculopathy, complex chronic pain syndrome, cervical radicular pain, cervicogenic headaches and low back pain. Subjective complaints include voice weakness, loss of voice, dysphagia to solids and liquids, dysphonia, pain when talking for prolonged periods of time, low back and bilateral lower extremity pain rated 6-7/10 and weakness, numbness and tingling to hands, decreased appetite and fatigue. Objective findings include mucosal edema, antalgic gate, tenderness to palpation over the bilateral paracervical musculature; cervical range of motion: flexion 15 degrees, extension, 10, right lateral flexion 10, left lateral flexion 10; positive cervical crepitus on motion; positive straight leg raise, tenderness to palpation over the musculature from L1-S1, palpable lumbar muscle spasm. Treatment has consisted of physical therapy, caudal epidural steroid injections, acupuncture, H-wave unit, trigger point injections, Norco, Ambien, Oxycodone, Trazodone, Ibuprofen, Viagra, Laxacin, Lidoderm, Topamax, Lyrica, Methocarbamol, Oxycontin, Morphine, Temazepam, Baclofen, Tizanidine, Flexeril, Dilaudid, Sonata, Percocet, cervical vertebral fusion, lumbar discectomy. The utilization review determination was rendered on 10/31/2014 recommending non-certification of Swallowing treatment x 12, Speech Therapy x 12 and Voice Evaluation x 2.

IMR ISSUES, DECISIONS AND RATIONALES

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

Swallowing treatment x 12: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Management of Patient with Stroke: Identification and Management of Dysphagia, A National Clinical Guideline

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Head, Speech Therapy, Cognitive Therapy, Up to Date http://www.uptodate.com/contents/swallowing-disorders-and-aspiration-in-palliative-care-assessment-and-strategies-for-management?source=search_result&search=swallowing+treatment&selectedTitle=3%7E150

Decision rationale: According to the ODG, speech therapy is recommended when the following criteria are met: 1) a diagnosis of a speech, hearing, or language disorder resulting from injury, trauma, or a medically based illness or disease. 2) clinically documented functional speech disorder resulting in an inability to perform at the previous functional level. 3) documentation supports an expectation by the prescribing physician that measurable improvement is anticipated in 4-6 months. 4) The level and complexity of the services requested can only be rendered safely and effectively by a licensed speech and language pathologist or audiologist. 5) Treatment beyond 30 visits requires authorization. UptoDate states "Assessment and management of dysphagia should adhere to the following palliative care principles: (1) prevention and relief of suffering and an emphasis on ensuring comfort, rather than optimal nutrition and hydration, are the primary goals; (2) the care plan should reflect the prognosis of the underlying life-threatening disease, be consistent with the overall goals of treatment, and there should be a plan for how care can be adjusted as the disease evolves; (3) care is optimized by involvement of an interdisciplinary team whereby each specialist contributes his/her expert knowledge; and (4) the patient and family are the unit of care and their wishes and preferences should guide collaborative decision making. Treatment goals are individualized to the patient and may range from attempts to improve swallow function, maximizing residual swallowing ability, or maintaining some oral intake for pleasure, as well as ensuring the safety and efficiency of nutrition administered by a different route". UPTO date also states "Physical examination -- The goal of the examination is to expose the factors responsible for the dysphagia and to predict the effectiveness of treatment strategies. Compensatory swallowing strategies -- The physiologic information obtained from clinical and instrumental swallowing assessment facilitates the selection of intervention strategies that are aimed at increasing swallowing safety and efficiency (table 5 and table 6). The chief advantage of these strategies is that they are simple for the patient to learn and to perform independently. Compensatory swallow strategies are aimed at altering head or neck posture to redirect bolus flow, heightening sensory awareness, or changing bolus characteristics to improve the safety of swallowing". The management of dysphagia involves a comprehensive speech therapy approach that involves swallowing evaluation and reevaluation, speech/voice therapy, and dietary modifications to protect the airway. The most recent barium swallow noted the injured worker tolerated regular texture solids with the use of compensatory swallow strategies. Swallowing treatments are part of a comprehensive speech therapy program for a patient. As such, the request for Swallowing treatment x 12 is medically necessary.

Speech Therapy x 12: 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, Speech Therapy, Cognitive Therapy, Up to Date http://www.uptodate.com/contents/swallowing-disorders-and-aspiration-in-palliative-care-assessment-and-strategies-for-management?source=search_result&search=swallowing+treatment&selectedTitle=3%7E150.

Decision rationale: According to the ODG, speech therapy is recommended when the following criteria are met: 1) a diagnosis of a speech, hearing, or language disorder resulting from injury, trauma, or a medically based illness or disease. 2) clinically documented functional speech disorder resulting in an inability to perform at the previous functional level. 3) documentation supports an expectation by the prescribing physician that measurable improvement is anticipated in 4-6 months. 4) the level and complexity of the services requested can only be rendered safely and effectively by a licensed speech and language pathologist or audiologist. 5) treatment beyond 30 visits requires authorization. UptoDate states "Assessment and management of dysphagia should adhere to the following palliative care principles: (1) prevention and relief of suffering and an emphasis on ensuring comfort, rather than optimal nutrition and hydration, are the primary goals; (2) the care plan should reflect the prognosis of the underlying life-threatening disease, be consistent with the overall goals of treatment, and there should be a plan for how care can be adjusted as the disease evolves; (3) care is optimized by involvement of an interdisciplinary team whereby each specialist contributes his/her expert knowledge; and (4) the patient and family are the unit of care and their wishes and preferences should guide collaborative decision making. Treatment goals are individualized to the patient and may range from attempts to improve swallow function, maximizing residual swallowing ability, or maintaining some oral intake for pleasure, as well as ensuring the safety and efficiency of nutrition administered by a different route". UPTO date also states "Physical examination -- The goal of the examination is to expose the factors responsible for the dysphagia and to predict the effectiveness of treatment strategies. Compensatory swallowing strategies -- The physiologic information obtained from clinical and instrumental swallowing assessment facilitates the selection of intervention strategies that are aimed at increasing swallowing safety and efficiency (table 5 and table 6). The chief advantage of these strategies is that they are simple for the patient to learn and to perform independently. Compensatory swallow strategies are aimed at altering head or neck posture to redirect bolus flow, heightening sensory awareness, or changing bolus characteristics to improve the safety of swallowing". The management of dysphagia involves a comprehensive speech therapy approach that involves swallowing evaluation and reevaluation, speech/voice therapy, and dietary modifications to protect the airway. The most recent barium swallow noted the injured worker tolerated regular texture solids with the use of compensatory swallow strategies. As such, the request for Speech Therapy x 12 is medically necessary.

Voice Evaluation x 2: 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, Speech Therapy, Cognitive Therapy, Up to Date http://www.uptodate.com/contents/swallowing-disorders-and-aspiration-in-palliative-care-assessment-and-strategies-for-management?source=search_result&search=swallowing+treatment&selectedTitle=3%7E150.

Decision rationale: According to the ODG, speech therapy is recommended when the following criteria are met: 1) a diagnosis of a speech, hearing, or language disorder resulting from injury, trauma, or a medically based illness or disease. 2) clinically documented functional speech disorder resulting in an inability to perform at the previous functional level. 3) documentation supports an expectation by the prescribing physician that measurable improvement is anticipated in 4-6 months. 4) the level and complexity of the services requested can only be rendered safely and effectively by a licensed speech and language pathologist or audiologist. 5) treatment beyond 30 visits requires authorization. UptoDate states "Assessment and management of dysphagia should adhere to the following palliative care principles: (1) prevention and relief of suffering and an emphasis on ensuring comfort, rather than optimal nutrition and hydration, are the primary goals; (2) the care plan should reflect the prognosis of the underlying life-threatening disease, be consistent with the overall goals of treatment, and there should be a plan for how care can be adjusted as the disease evolves; (3) care is optimized by involvement of an interdisciplinary team whereby each specialist contributes his/her expert knowledge; and (4) the patient and family are the unit of care and their wishes and preferences should guide collaborative decision making. Treatment goals are individualized to the patient and may range from attempts to improve swallow function, maximizing residual swallowing ability, or maintaining some oral intake for pleasure, as well as ensuring the safety and efficiency of nutrition administered by a different route". UPTO date also states "Physical examination -- The goal of the examination is to expose the factors responsible for the dysphagia and to predict the effectiveness of treatment strategies. Compensatory swallowing strategies -- The physiologic information obtained from clinical and instrumental swallowing assessment facilitates the selection of intervention strategies that are aimed at increasing swallowing safety and efficiency (table 5 and table 6). The chief advantage of these strategies is that they are simple for the patient to learn and to perform independently. Compensatory swallow strategies are aimed at altering head or neck posture to redirect bolus flow, heightening sensory awareness, or changing bolus characteristics to improve the safety of swallowing". The management of dysphagia involves a comprehensive speech therapy approach that involves swallowing evaluation and reevaluation, speech/voice therapy, and dietary modifications to protect the airway. The most recent barium swallow noted the injured worker tolerated regular texture solids with the use of compensatory swallow strategies. Voice evaluations are part of a comprehensive speech therapy program for a patient. As such, the request for Voice Evaluation x 2 is medically necessary.