MAXIMUS Federal Services

Case Number:	CM14-0189731		
Date Assigned:	11/20/2014	Date of Injury:	11/13/2011
Decision Date:	01/08/2015	UR Denial Date:	10/30/2014
Priority:	Standard	Application Received:	11/13/2014

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 Occupational Medicine and is licensed to practice in Montana. 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 an assistant drug store manager with dates of injury of 9/6/11 and 11/13/11. These injuries occurred at work when a box fell onto his head and another incident where he was assaulted by a customer. Since these injuries he has continued to complain of headache, neck pain and stiffness, dizziness, fatigue and depression. He initially did have a CT scan and EEG performed which were normal. He did have a brain MRI performed on 6/30/14 however that report is not available for review. He has had chiropractic treatment and medication management. Medications have included Effexor, Naprosyn, Lidoderm Patch, omeprazole and meclizine. The primary treating physician has requested blood work to include complete blood count, thyroid-stimulating hormone, liver function test, erythrocyte sedimentation rate and antinuclear antibodies.

IMR ISSUES, DECISIONS AND RATIONALES

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

Blood Work: Complete Blood Count, Thyroid Stimulating Hormone, Liver Function test, Erythrocyte Sedimentation Rate, and Antinuclear Antibodies: Upheld

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 Other Medical Treatment Guideline or Medical Evidence: American Society of Anesthesiologist Task Force for Pre-anesthesia Evaluation

Decision rationale: The MTUS does not address blood work for complete blood count, thyroid-stimulating hormone, liver function test, erythrocyte sedimentation rate and antinuclear antibodies. The primary treating physician has noted that they are requested to determine if there is another chronic medical condition that contributes to delayed recovery. The Utilization Review (UR) of 10/30/14 did not certify this request, noting that routine preoperative testing in asymptomatic patients does not make a significant contribution to preoperative assessment and patient management. After review of the provided medical records it is not apparent that this request is preoperative in nature. The records provided do not justify the request for laboratory testing that is not specific in nature and related to work injuries that occurred over 3 years ago. The request for blood work for complete blood count, thyroid-stimulating hormone, liver function test, erythrocyte sedimentation rate and antinuclear antibodies is not supported by the MTUS and is not medically necessary.

Audiology Assessment: 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), Audiometry

Decision rationale: The ODG guidelines recommended an audiogram following brain injury or when occupational hearing loss is suspected. Audiometry is a generally accepted and well-established procedure that measures hearing. An audiologist or skilled trained technician administers the test using an audiometer. The machine presents individual frequencies to the patient (typically ranging from 125-8000 Hz) at different levels of loudness (in dBHL). The patient is asked to respond to the sound that he may barely perceive (threshold). Normal thresholds are from 0-25dBHL. The results are displayed in normal graphic form or on audiogram. The audiologist or physician may determine the presence and type (conductive, sensorineural, or mixed) of hearing loss based on the audiogram. Baseline audiometry following brain injury is indicated when the individual with TBI presents with hearing loss, dizziness, tinnitus, or facial nerve dysfunction. Audiograms may be obtained in serial fashion to monitor inner ear function in response to time and treatment. (Mueller, 2005) Clinical indications from the American Speech Hearing Association (ASHA), the professional, scientific, and credentialing association for audiologists, include: (1) Screen as needed, requested, or when patients have conditions that place them at risk for hearing impairment, such as recreational noise exposure, family history and concern of family member; & (2) Screen at least every decade through age 50 and at 3-year intervals thereafter. The Panel also recommended a three-component screening protocol for adults. This should include screening for hearing disorder, hearing impairment and hearing disability. Prior to the hearing screening, a case history and visual inspection of the ear is advised to identify persons with significant otologic history or obvious anatomic abnormalities of the ear. The pure tone hearing screening should to be

conducted at 25 dB HL for 1000, 2000 and 4000 Hz in each ear. Hearing impairment is defined as unilateral or bilateral sensorineural and/or conductive hearing levels greater than 20 dB HL. (ASHA, 2011)In this case the injured worker has not had an audiogram following his traumatic head injuries. The guidelines note that baseline audiometry following brain injury is indicated when the individual with TBI presents with hearing loss, dizziness, tinnitus, or facial nerve dysfunction. He has had persistent dizziness and baseline audiogram is indicated. I am reversing the prior UR decision. My decision is that audiology assessment is medically necessary.