

Case Number:	CM14-0203319		
Date Assigned:	12/15/2014	Date of Injury:	04/24/2014
Decision Date:	02/05/2015	UR Denial Date:	11/18/2014
Priority:	Standard	Application Received:	12/04/2014

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 a refuse truck driver with a date of injury of 4/24/14. The injury was a rollover motor vehicle accident resulting in head injury and significant burns to the abdomen, right flank, buttocks and perineum. He would require split thickness grafting. Initial brain imaging did reveal interventricular hemorrhage and subarachnoid hemorrhage. He would have extensive physical/occupational therapy. He currently requires pain medication. Ongoing symptoms include cervical pain, headaches, fatigue, frequent tripping, disorientation, slowed speech, facial asymmetry, transient diplopia, and poor memory and cognition. His current diagnoses include post-concussive syndrome with headaches, cervicgia, traumatic brain injury, TMJ syndrome, diplopia, dizziness, cognitive disorder and convergence disorder. The primary treating physician has requested MRI of the brain without contrast, pain psychological evaluation and treatment and one vestibular evaluation.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI of the Brain without Contrast: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines Head

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

Decision rationale: Recommended as indicated below. Magnetic Resonance Imaging (MRI) is a well-established brain imaging study in which the individual is positioned in a magnetic field and a radio-frequency pulse is applied. Hydrogen proton energy emission is translated into visualized structures. Normal tissues give off one signal, while abnormal structures give off a different signal. Due to its high contrast resolution, MRI scans are superior to CT scans for the detection of some intracranial pathology, except for bone injuries such as fractures. MRI may reveal an increased amount of pathology as compared with CT. Specific MRI sequences and techniques are very sensitive for detecting traumatic cerebral injury; they may include, but are not limited to, diffusion-tensor, gradient echo, and Fluid Attenuated Inversion Recovery (FLAIR). Some of these techniques are not available on an emergency basis. MRI scans are useful to assess transient or permanent changes, to determine the etiology of subsequent clinical problems, and to plan treatment. MRI is more sensitive than CT for detecting traumatic cerebral injury. (Colorado, 2005) (Intracorp, 2005) (Takanashi, 2001) Neuroimaging is not recommended in patients who sustained a concussion/mild TBI beyond the emergency phase (72 hours post-injury) except if the condition deteriorates or red flags are noted. Indications for magnetic resonance imaging: To determine neurological deficits not explained by CT To evaluate prolonged interval of disturbed consciousness To define evidence of acute changes super-imposed on previous trauma or disease In this case initial brain imaging was performed following his injury. The medical records do not document new neurologic deficits, evidence of acute changes superimposed on previous trauma or disease, or any additional prolonged interval of disturbed consciousness. The request for MRI of the brain without contrast is not medically necessary.

1 Pain Psychological Evaluation and Treatment: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Psychological Evaluations.

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

Decision rationale: Recommended for appropriately identified patients during treatment for chronic pain. Psychological intervention for chronic pain includes setting goals, determining appropriateness of treatment, conceptualizing a patient's pain beliefs and coping styles, assessing psychological and cognitive function, and addressing co-morbid mood disorders (such as depression, anxiety, panic disorder, and posttraumatic stress disorder). Cognitive behavioral therapy and self-regulatory treatments have been found to be particularly effective. Psychological treatment incorporated into pain treatment has been found to have a positive short-term effect on pain interference and long-term effect on return to work. The following "stepped-care" approach to pain management that involves psychological intervention has been suggested: Step 1: Identify and address specific concerns about pain and enhance interventions that emphasize self-management. The role of the psychologist at this point includes education and training of pain care providers in how to screen for patients that may need early psychological intervention. Step 2: Identify patients who continue to experience pain and disability after the usual time of recovery. At this point a consultation with a psychologist allows

for screening, assessment of goals, and further treatment options, including brief individual or group therapy. Step 3: Pain is sustained in spite of continued therapy (including the above psychological care). Intensive care may be required from mental health professions allowing for a multidisciplinary treatment approach. Several recent reviews support the assertion of efficacy of cognitive-behavioral therapy (CBT) in the treatment of pain, especially chronic back pain (CBP). ODG Psychotherapy Guidelines:- Up to 13-20 visits over 7-20 weeks (individual sessions), if progress is being made.(The provider should evaluate symptom improvement during the process, so treatment failures can be identified early and alternative treatment strategies can be pursued if appropriate.)- In cases of severe Major Depression or PTSD, up to 50 sessions if progress is being made.In this case the Utilization Review of 11/18/14 did approve 1 pain psychological evaluation. Additional approval for treatment was deferred pending the initial evaluation. Additional visits for treatment should specify the number of visits over a specific period of time. The request for psychological evaluation and treatment is not medically necessary.

1 Vestibular Evaluation: 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)

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

Decision rationale: Recommended as indicated below. Vestibular studies assess the function of the vestibular portion of the inner ear for patients who are experiencing symptoms of vertigo, unsteadiness, dizziness, and other balance disorders. The vestibular portion of the inner ear maintains balance through receptors that process signals produced by motions of the head and the associated responsive eye reflexes that result in the visual perception of how the body is moving. Vestibular function studies should be performed by licensed audiologists or a registered audiology aide working under the direct (physically present) supervision of the audiologist. Alternately, they can be performed by a physician or personnel operating under a physician's supervision. (Curthoys, 2010) Clinicians need to assess and identify vestibular impairment following concussion using brief screening tools to allow them to move patients into targeted treatment tracks that will provide more individualized therapies for their specific impairments. (Kontos, 2013) Patients with mild traumatic brain injury (TBI) often complain of dizziness. However, these problems may be undetected by a clinical exam. Balance was tested using computerized dynamic posturography (CDP). These objective measurement techniques should be used to assess the clinical complaints of imbalance from patients with TBI. In this case the injured worker does have a diagnosis of dizziness with documentation of gait disturbance. The records do not show that there has been a previous vestibular evaluation to determine whether there is a vestibular component to those symptoms. Given his significant traumatic brain injury, I am reversing the prior UR decision. The request for 1 vestibular evaluation is medically necessary.