

Case Number:	CM15-0108460		
Date Assigned:	06/15/2015	Date of Injury:	04/25/2013
Decision Date:	07/14/2015	UR Denial Date:	05/26/2015
Priority:	Standard	Application Received:	06/05/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
 State(s) of Licensure: New Jersey, Alabama, California
 Certification(s)/Specialty: Neurology, Neuromuscular Medicine

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 35 year old male injured worker suffered an industrial injury on 04/25/2013. The diagnoses included right shoulder pain, cervical discogenic pain, stenosis, bilateral carpal tunnel syndrome, cervical facet pain, rotator cuff injury, biceps tendinosis, chronic pain syndrome, and myofascial pain. The diagnostics included neurological consult, head computerized tomography, cervical magnetic resonance imaging, magnetic resonanace arthrogram right shoulder, and electro-myographic studies. The injured worker had been treated with massage therapy, medications, physical therapy, and H-wave therapy. On 5/15/2015, the treating provider reported right shoulder pain, neck pain, headaches and light headedness. There was numbness in the right hand. The pain was rated 4/10 and worse since last appointment. On exam, there was tenderness of the cervical muscles and facet joints on the right with reduced range of motion. The neurologist constult recommended repeat of neuropsychological evaluation. The treatment plan included Neuropsychological re-evaluation and Balance & Vestibular rehabilitation sessions.

IMR ISSUES, DECISIONS AND RATIONALES

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

Neuropsychological re-evaluation qty 1.00: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Consultations Chapter (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 7), page 127.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Neuropsychological testing. <http://www.odg-twc.com/index.html>.

Decision rationale: According to ODG guidelines, Neuropsychological testing "Recommended for severe traumatic brain injury, but not for concussions unless symptoms persist beyond 30 days. For concussion/ mild traumatic brain injury, comprehensive neuropsychological/cognitive testing is not recommended during the first 30 days post injury, but should symptoms persist beyond 30 days, testing would be appropriate. Neuropsychological testing should only be conducted with reliable and standardized tools by trained evaluators, under controlled conditions, and findings interpreted by trained clinicians. Moderate and severe TBI are often associated with objective evidence of brain injury on brain scan or neurological examination (e.g., neurological deficits) and objective deficits on neuropsychological testing, whereas these evaluations are frequently not definitive in persons with concussion/mTBI. There is inadequate/insufficient evidence to determine whether an association exists between mild TBI and neurocognitive deficits and long-term adverse social functioning, including unemployment, diminished social relationships, and decrease in the ability to live independently. Attention, memory, and executive functioning deficits after TBI can be improved using interventions emphasizing strategy training (i.e., training patients to compensate for residual deficits, rather than attempting to eliminate the underlying neurocognitive impairment) including use of assistive technology or memory aids. (Cifu, 2009) Neuropsychological testing is one of the cornerstones of concussion and traumatic brain injury evaluation and contributes significantly to both understanding of the injury and management of the individual. The computer-based programs Immediate Post concussion Assessment and Cognitive Testing (ImPACT), CogSport, Automated Neuro-psychological Assessment Metrics (ANAM), Sports Medicine Battery, and Head Minder may have advantages over paper-and-pencil neuropsychological tests such as the McGill Abbreviated Concussion Evaluation (ACE) and the Standardized Assessment of Concussion (SAC). (Cantu, 2006) The application of neuropsychological (NP) testing in concussion has been shown to be of clinical value and contributes significant information in concussion evaluation, but NP assessment should not be the sole basis of management decisions. Formal NP testing is not required for all athletes, but when it is considered necessary, it should be performed by a trained neuropsychologist. Baseline NP testing is not required as an aspect of every assessment, but it may be helpful to add useful information to the overall interpretation of the tests. Persistent symptoms (>10 days) are generally reported in 10-15% of concussions, at which point investigations may include formal neuropsychological testing and conventional neuroimaging to exclude structural pathology. (McCrory, 2013) In cases of multiple concussions/ persistent impairment, professional athletes should be referred for neurologic and neuropsychological assessment, and amateur athletes should have formal neurologic/ cognitive assessment and risk factor counseling. (Giza, 2013)" The patient underwent a previous neuropsychological evaluation and there is no justification to repeat another evaluation. There is no documentation of change or progression of the patient condition to justify another evaluation. Therefore, the request for Neuropsychological re-evaluation qty 1.00 is not medically necessary.

Balance & Vestibular rehabilitation sessions Qty 6.00: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Vestibular PT rehabilitation. <http://www.odg-twc.com/index.html>.

Decision rationale: According to ODG guidelines, Vestibular PT rehabilitation "Recommended for patients with vestibular complaints (dizziness and balance dysfunction), such as with mTBI/concussion. Vestibular rehabilitation has been shown to be associated with improvements in independence and dynamic visual acuity." There is no documentation that the patient developed vestibular dysfunction. Therefore, the request for Balance & Vestibular rehabilitation sessions Qty 6.00 is not medically necessary.