MAXIMUS Federal Services

Case Number:	CM15-0018116		
Date Assigned:	03/18/2015	Date of Injury:	08/28/2006
Decision Date:	04/16/2015	UR Denial Date:	01/09/2015
Priority:	Standard	Application Received:	01/30/2015

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: Texas, Florida, California
Certification(s)/Specialty: Preventive Medicine, Occupational 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:

This 59 year old male sustained an industrial injury on 8/28/06, with blunt force trauma to the face and head and loss of consciousness. The injured worker subsequently developed seizures, headaches, neck pain, low back pain and extremity pain. In a PR-2 dated 12/17/14, the physician noted that the injured worker was status post an epidural steroid injection on 9/8/14, with subsequent vomiting, increased headache for days and no improvement. The injured worker complained of sharp headaches, stomach pain, lumbar spine pain, cervical spine pain, dizziness, blurry vision, depression and insomnia. The injured worker had had no seizure activity since 11/13. Current diagnoses included seizures, headaches, diabetes mellitus and rule out obstructive sleep apnea. The treatment plan included electroencephalogram, polysomnogram, refill Divlproex and Vimpat, neuropsychologic testing, transportation to and from medical and legal appointments, ambulatory electroencephalogram telemetry and dental evaluation as per the recommendations cited in a medical-legal neurological report dated 10/10/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

Vimpat 100MG #60: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Curr Treat Options Neurol. 2010 Sep; 12(5): 434-442. Stopping Antiepileptic Drugs: When and Why? John D. Hixson, MD.

Decision rationale: The MTUS, and the ODG are silent in regards to this medicine. The evidence-based neurologic reference does note that after a patient has initiated an antiepileptic drug (AED) and achieved a sustained period of seizure freedom, the rate of seizure recurrence after AED withdrawal is about two to three times the rate in patients who continue AEDs. AED discontinuation may be considered in patients whose seizures have been completely controlled for a prolonged period, and 2 to 5 years for adults. The claimant's last seizure was in November 2013. The PR2 was from December 2014. An ESI was poorly received. In this case, it is noted the first reviewer, a Neurologist, did in fact approve the Divalproex 800 mg #90. This was due to the risk of withdrawal symptoms from abrupt discontinuation. It was for Divalproex 500 mg #90, medicine is for complex partial seizures. It was mistakenly shown in the IMR as being submitted for review for non-approval, but it actually was approved. I do agree with the first reviewer's certification of at least one anti-seizure medicine, as insufficient time had elapsed to consider withdrawing the patient from all anti-seizure medicines. However, it is not clear why a second antiseizure medicine, Vimpat, was clinically needed. Vimpat 100 mg #60 is lacosamide. Per the PDR, it is for partial seizures as a monotherapy [i.e. no other agents are needed with it]. Considering the failure to submit the evidence of objective functional improvement with prior use, and without clear evidence to support the diagnosis, I agree with the non-certification of the Vimpat.

EEG: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG-TWC, criteria for EEG, (electroencephalography).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation http://www.mdguidelines.com/electroencephalogram.

Decision rationale: The MTUS and ODG are silent on this test. Per the evidence-based reference, electroencephalography is the process of recording brain wave activity. During neurosurgery, an electrode can be applied directly to the surface of the brain (intracranial electroencephalography) or placed within the brain tissue (depth electroencephalography) to detect brain tumors or lesions. A flat or isoelectric EEG is one in which no brain waves are recorded, indicating a complete lack of brain activity, consistent with brain death. The test is used to diagnose seizure disorders, brainstem disorders, local (focal) brain tumors or lesions, head injuries, confusion, and impaired consciousness. EEGs are also done to investigate sleep disturbances such as narcolepsy or sleep apnea and other sleep disturbances. It can also help in the evaluation of coma, stroke, tremor, Alzheimer's disease, certain types of dementia, cerebrovascular disease, and brain death. In this case, the claimant is not at the point where

withdrawal of anti-seizure medicine is appropriate, and so it is too early to re-do the EEG. The request was appropriately non-certified.

Polysomnogram: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Duration Advisor, in the Head Section, under Polysomnogram.

Decision rationale: The current California web-based MTUS collection was reviewed in addressing this request. The guidelines are silent in regards to this request. Therefore, in accordance with state regulation, other evidence-based or mainstream peer-reviewed guidelines will be examined. The ODG notes regarding sleep studies: Criteria for Polysomnography: In-lab polysomnograms/sleep studies are recommended for the combination of indications listed: (1) Excessive daytime somnolence; (2) Cataplexy (muscular weakness usually brought on by excitement or emotion, virtually unique to narcolepsy); (3) Morning headache (other causes have been ruled out); (4) Intellectual deterioration (sudden, without suspicion of organic dementia); (5) Personality change (not secondary to medication, cerebral mass or known psychiatric problems); (6) Insomnia complaint for at least six months (at least four nights of the week), unresponsive to behavior intervention and sedative/sleep-promoting medications and psychiatric etiology has been excluded. A sleep study for the sole complaint of snoring, without one of the above mentioned symptoms, is not recommended. In this case, the claimant does have increased headache, but it appears temporarily associated with an ESI. The doctor notes they wish to rule out sleep apnea, but there is no documentation of daytime somnolence, morning headache, cataplexy, and again, no documentation of intellectual deterioration or personality change. The request does not meet criteria for the test and therefore, was appropriately non-certified.

Neuropsyche testing: 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 Emedicine.com, under Neuropsychological Testing.

Decision rationale: The MTUS, ODG and MDA are silent on neurocognitive testing. Per Emedicine.com: Neuropsychological evaluation (NPE) is a testing method through which a neuropsychologist can acquire data about a subject's cognitive, motor, behavioral, linguistic, and executive functioning. In the hands of a trained neuropsychologist, these data can provide information leading to the diagnosis of a cognitive deficit or to the confirmation of a diagnosis, as well as to the localization of organic abnormalities in the central nervous system (CNS). The data can also guide effective treatment methods for the rehabilitation of impaired patients. NPE provides insight into the psychological functioning of an individual, a capacity for which modern

imaging techniques[1, 2] have only limited ability. However, these tests must be interpreted by a trained, experienced neuropsychologist in order to be of any benefit to the patient. These tests are often coupled with information from clinical reports, physical examination, and increasingly, premorbid and post morbid self and relative reports. Alone, each neuropsychological test has strengths and weaknesses in its validity, reliability, sensitivity, and specificity. However, through eclectic testing and new in situ testing, the utility of NPE is increasing dramatically [3, 4]."In this case, there were no focused neurocognitive dysfunction noted on a neurologic exam or mini-mental status exam that might suggest there is a neurocognitive disorder. The clinical necessity of this test is not established in the records.

Dental evaluation: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management Page(s): ACOEM, Chapter 5, and 7 primarily page 127.

Decision rationale: ACOEM notes that the occupational health practitioner may refer to other specialists if a diagnosis is uncertain or extremely complex, when psychosocial factors are present, or when the plan or course of care may benefit from additional expertise. A referral may be for consultation to aid in the diagnosis, prognosis, therapeutic management, determination of medical stability, and permanent residual loss and/or the examinee's fitness for return to work. A consultant is usually asked to act in an advisory capacity, but may sometimes take full responsibility for investigation and/or treatment of an examinee or patient. This request for the consult fails to specify the concerns to be addressed in the independent or expert assessment, including the relevant medical and non-medical issues, diagnosis, causal relationship, prognosis, temporary or permanent impairment, work capability, clinical management, and treatment options. The request is appropriately not certified.

Transportation to medical and legal appointments: 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 Official Disability Guidelines (ODG) Knee, Transportation and Other Medical Treatment Guidelines California Labor Code 4600(a).

Decision rationale: The only guidance on this matter of transportation is in ODG, which notes: Recommended for medically-necessary transportation to appointments in the same community for patients with disabilities preventing them from self-transport. (CMS, 2009) It is not clear that the patient's impairment reaches a level of disability, and that other arrangements are not possible. Also, how one gets to appointments is not a medical treatment under California guidelines is not medical care. Labor Code 4600(a) notes that care is medical, surgical, chiropractic, acupuncture, and hospital treatment including nursing, medicines, medical and

surgical supplies, crutches and apparatuses, including orthotic and prosthetic devices and services, that is reasonably required to cure or relieve the injured worker from the effects of his or her injury shall be provided by the employer. There is insufficient information to say such a request should be medically certified.

Ambulatory EEG Telemetry or admission to Base Telemetry: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)-TWC, criteria for EEG, (electroencephalography).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation The Medical Disability Guidelines under Electroencephalogram http://www.mdguidelines.com/electroencephalogram.

Decision rationale: The MTUS and ODG are silent on this form of EEG test. This is simply a form of EEG, which was previously evaluated; the only difference is how it is collected i.e. with an ambulatory unit the person wears, or telemetry of data to a central location. The basic question remains, however, as to whether or not EEG itself is clinically necessary. As shared in a previous question, per the evidence-based reference, electroencephalography is the process of recording brain wave activity. During neurosurgery, an electrode can be applied directly to the surface of the brain (intracranial electroencephalography) or placed within the brain tissue (depth electroencephalography) to detect brain tumors or lesions. A flat or isoelectric EEG is one in which no brain waves are recorded, indicating a complete lack of brain activity, consistent with brain death. The test is used to diagnose seizure disorders, brainstem disorders, local (focal) brain tumors or lesions, head injuries, confusion, and impaired consciousness. EEGs are also done to investigate sleep disturbances such as narcolepsy or sleep apnea and other sleep disturbances. It can also help in the evaluation of coma, stroke, tremor, Alzheimer's disease, certain types of dementia, cerebrovascular disease, and brain death. In this case, the claimant is not at the point where withdrawal of anti-seizure medicine is appropriate, and so it is too early to re-do the EEG, regardless of how the data is collected or transmitted. The request was appropriately non-certified.