

Case Number:	CM15-0163830		
Date Assigned:	09/01/2015	Date of Injury:	11/22/2014
Decision Date:	09/30/2015	UR Denial Date:	07/22/2015
Priority:	Standard	Application Received:	08/20/2015

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 York, Tennessee

Certification(s)/Specialty: Emergency 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 injured worker is a 63 year old female who sustained an injury on 11-22-14 resulting when she began to descend stairs when she slipped and fell hitting her head. There was loss of consciousness and laceration to right upper forehead region. Diagnosis testing included a CT scan and an MRI of the brain on 2-3-15. The examination from 6-15-15 reports the pain level is 8 out of 10 and the pain is in her neck, left posterior shoulder that radiates up to her head; pain in left shoulder, low back and left knee. She is in cognitive behavior therapy and is tolerating her medications. Symptoms of vision issues in the right eye include on occasion half the visual field goes away and then come back. A recommendation for a re-evaluation with neuro-ophthalmologist concerning her vision issues in the right eye is noted. Medications at this exam include Flexeril 10 mg; Nortriptyline 10 mg one table every night 1-3 tablets #90; Relafen 500 mg 1-2 as needed for pain and Norco 5-325 mg. An examination on 7-20-15 reports the IW remains unchanged with a pain level at 9 out of 10. A neuro-psych evaluation was done and found evidence of severe anxiety and depressive disorder along with severe somatic symptom disorder. The prognosis was noted to be good and recommended individual psychotherapy to address the severe anxiety and depression. The IW continues to complain of vision problems that involve decreased vision on the right that was secondary to a more severe cataract on the right than the left. Diagnoses are concussion, cervical sprain, with underlying degenerative cervical disc disease, right hip sprain with underlying degenerative arthritis, myofascial pain syndrome: neck, right hip; vision abnormalities secondary to cataract and possible vitreous detachment. The examination notes multiple tender trigger point over her neck and posterior shoulder and appears depressed and anxious. Medications include Nortriptyline 10 mg 3-5 tablet

every night #90; Norco 5-325 mg twice a day as needed #30; Relafen 500 mg as needed; Fiorecet 1 tab for pain #60; Flexeril was stopped. Work status is modified duty. Current requested treatments 2 visits neuro-Ophthalmology re-evaluations; Nortriptyline 10 mg #90 (dispensed 6-15-15)

IMR ISSUES, DECISIONS AND RATIONALES

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

2 visits neuro-ophthalmology re-evaluation: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM page 127.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation UpToDate: Retinal detachment.

Decision rationale: Posterior vitreous detachment (PVD) is the most common cause of retinal tears which often lead to rhegmatogenous retinal detachment. The vitreous is a clear gel-like structure in the back of the eye composed of collagen fibrils and hyaluronic acid that slowly liquefies throughout life. These pockets of liquid can break through the posterior vitreous face and cause PVD from the retina. This event, which occurs typically in patients between the ages of 50 and 75 years, results in a new onset of cobweb-like floaters and/or increased floaters (see below). Most patients, who present with PVD and do not have any retinal breaks or retinal tears on a 360-degree scleral depressed examination, require only reassurance and education. In a meta-analysis of retrospective studies that included 1600 patients with symptomatic PVD, delayed retinal tears (not seen on initial examination) were found in 1.8 percent; 83 percent of the patients with late tears had vitreous or retinal hemorrhage at initial examination, or developed new symptoms. While studies have tried to identify subsets of patients who may not require additional evaluation after the initial examination, we suggest that most patients should be seen in follow-up at about three months. Patients who describe photopsias, or have evidence of retinal bleeding, but no full-thickness or retinal detachment, may require an earlier follow-up in approximately one to two months. The floaters often resolve over a period of 3 to 12 months; they settle down outside the visual axis, and/or become less noticeable or bothersome. In some cases, however, floaters may be a permanent symptom, and if disabling may require vitrectomy to treat. In general, patients with a PVD do not require any specific activity limitations. Patients who develop worsening symptoms of flashes, significantly more floaters, and/or loss of peripheral or central vision should be reevaluated with a careful scleral depressed peripheral retinal examination. In this case, the patient was diagnosed with posterior vitreous detachment with no holes or retinal detachment. There is no documentation of progression of the patient's symptoms. Treatment is reassurance and education. The request for 2 follow up visits with neuro-ophthalmologist surpasses the one follow up visit recommended. The request should not be authorized.