

Case Number:	CM15-0166062		
Date Assigned:	09/03/2015	Date of Injury:	10/21/2014
Decision Date:	10/23/2015	UR Denial Date:	08/07/2015
Priority:	Standard	Application Received:	08/24/2015

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: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 57 year old male who sustained a work related injury October 21, 2014, after falling from a 20 foot ladder with loss of consciousness. He was diagnosed status post mechanical fall with head trauma and right acetabular fracture. Past history included diabetes mellitus, hypertension, Von Willebrand disease, atrial fibrillation, sleep apnea, and deep vein thrombosis on Coumadin, post-surgical aortic root aneurysm repair, aortic valve replacement x 3, pacemaker, hernia repair, and knee arthroscopy. On March 20, 2015, the injured worker underwent bilateral parietal burr hole, evacuation of subdural collection, insertion of subdural drain for a diagnosis of bilateral subdural hygroma. A treating physician's discharge summary dated March 27, 2015, documented the injured worker underwent a repeat CT scan which suggested a small epidural hygroma on the left frontal and parietal lobes with post-operative pneumocephalus decreased since prior exam. A physician's consultation (otolaryngology head and neck surgery) dated May 5, 2015, found the injured worker complaining of tinnitus bilaterally. He noted it has been present since the original injury October 21, 2014. There is some hearing loss; however, the main symptom is the constant tinnitus. Physical examination revealed tympanic membranes and ear canals are normal, there is no evidence of cholesteatoma, chronic infection, perforation, or ear drainage. The septum is midline. There is no evidence of neck mass or bruit. Complete audiometric evaluation was performed revealing a sensorineural hearing loss. Hearing aids may be indicated. He was diagnosed with post-traumatic tinnitus with recommendation of repeat audiometric evaluation in three months. At issue, is a request for authorization for a CT scan of the head without contrast and a follow-up consultation with

Otologist-ENT(ear nose and throat) specialist x 2 visits. According to utilization review, dated July 7, 2015, the request for a CT scan of the head without contrast is non-certified. The request for follow-up consultation with otologist-ENT specialist x 2 visits was modified to approve 1 consultation by an otologist ENT specialist.

IMR ISSUES, DECISIONS AND RATIONALES

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

CT scan of the head w/o 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 (ODG) Head (updated 07/24/2015)- Online Version.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Head Chapter under CT (computed tomography).

Decision rationale: The patient presents with dizziness and headaches. The patient is status post bilateral parietal burr hole, 03/25/15. The request is for CT Scan Of The Head w/o Contrast. The RFA is not provided. CT head dated 03/20/15, shows small bilateral subdural hygromas, new since prior; a tiny focus of hyperdensity within the right-sided hygroma may indicate recent hemorrhage; mild mass effect on the subadjacent sulci. CT Angiography of the head, 03/21/15, shows bilateral subdural hygromas. Left greater than right. CT head, 03/23/15, shows stable bilateral subdural hygromas, left greater than right, with mild mass effect on the subadjacent sulci and mild finding of the basal cistern; no abnormal intracranial enhancement; old right PICA territory infarct. CT head, 03/25/15, shows satisfactory appearance of intracranial compartment after surgical drainage of bilateral subdual collections; postoperative pneumocephalus is noted. CT head, 03/27/15, shows newly seen small epidural hygroma overlying the left frontal and parietal lobes; postoperative pneumocephalus is slightly decreased. Patient has no previous history of tinnitus, patient complains of bilateral tinnitus secondary to a fall in 10/2014. He has no history of ear drainage or pain. There is no vertigo. The patient denies any history of otitis media or ear surgery. Patient's medications include Metformin, Enalapril, Metoprolol, Zantac, Pravastatin, and Pepcid. The patient's work status is not provided. ODG Guidelines, Head Chapter under CT (computed tomography) Section states, "Recommended as indicated below. Indications for computed tomography: CT scans are recommended for abnormal mental status, focal neurologic deficits, or acute seizure and should also be considered in the following situations: Signs of basilar skull fracture; Physical evidence of trauma above the clavicles; Acute traumatic seizure; Age greater than 60; An interval of disturbed consciousness; Pre-or post-event amnesia; Drug or alcohol intoxication; Any recent history of TBI, including TBI. Also may be used to follow identified pathology or screen for late pathology. Subsequently, CT scans are generally accepted when there is suspected intracranial blood, extra-axial blood, hydrocephalus, altered mental states, or a change in clinical condition, including development of new neurological symptoms or post-traumatic seizure (within the first days following trauma). MRI scans are generally recommended as opposed to CT once the initial acute stage has passed. (Colorado, 2005)Patients presenting to the emergency department with headache and abnormal

findings in a neurologic examination (i.e., focal deficit, altered mental status, altered cognitive function) should undergo emergent non-contrast head computed tomography (CT) scan. (ACEP, 2002)" Per progress report dated 05/05/15, treater states, "Patient has posttraumatic tinnitus. Unfortunately, there is no specific treatment for this. I have discussed the fact that there is a sensorineural hearing loss, but [patient] does not appear to be having significant difficulty with this. Hearing aids may be indicated for tinnitus and/or hearing loss." Per UR letter dated 08/07/15, reviewer notes that "According to the Office Visit dated 07/23/15, the patient complained of persistent headaches, ringing in the ear, and also increasing hearing loss." In this case, while the patient has increased hearing loss, at least two CT scans have already been done postoperatively. Treater does not document any red flags or new exam findings demonstrating significant neurologic deficit to consider another repeat CT scan of the head. Therefore, the request is not medically necessary.

Follow-up consultation with Otologist/ ENT specialist x 2 visit: 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) Head (updated 07/24/2014)- Online Version.

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

Decision rationale: The patient presents with dizziness and headaches. The patient is status post bilateral parietal burr hole, 03/25/15. The request is for Follow-Up Consultation with Otologist/ ENT Specialist X 2 Visit. The RFA is not provided. CT head dated 03/20/15, shows small bilateral subdural hygromas, new since prior; a tiny focus of hyperdensity within the right-sided hygroma may indicate recent hemorrhage; mild mass effect on the subadjacent sulci. CT Angiography of the head, 03/21/15, shows bilateral subdural hygromas. Left greater than right. CT head, 03/23/15, shows stable bilateral subdural hygromas, left greater than right, with mild mass effect on the subadjacent sulci and mild finding of the basal cistern; no abnormal intracranial enhancement; old right PICA territory infarct. CT head, 03/25/15, shows satisfactory appearance of intracranial compartment after surgical drainage of bilateral subdual collections; postoperative pneumocephalus is noted. CT head, 03/27/15, shows newly seen small epidural hygroma overlying the left frontal and parietal lobes; postoperative pneumocephalus is slightly decreased. Patient has no previous history of tinnitus, patient complains of bilateral tinnitus secondary to a fall in 10/2014. He has no history of ear drainage or pain. There is no vertigo. The patient denies any history of otitis media or ear surgery. Patient's medications include Metformin, Enalapril, Metoprolol, Zantac, Pravastatin, and Pepcid. The patient's work status is not provided. ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 7, page 127 has the following: "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." Treater does not discuss the request. It would appear that the current treater feels uncomfortable with the patient's medical issues and has requested a follow-up consultation with Otologist/ENT Specialist. The patient continues with tinnitus and hearing loss. Given the patient's condition, the request for a follow-up consultation with Otologist/ENT Specialist appears reasonable. Therefore, the request is medically necessary.