MAXIMUS Federal Services

Case Number:	CM15-0187523		
Date Assigned:	09/29/2015	Date of Injury:	01/18/2008
Decision Date:	11/30/2015	UR Denial Date:	08/26/2015
Priority:	Standard	Application Received:	09/23/2015

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: 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 67-year-old male, who sustained an industrial injury on 1-18-08. He is diagnosed with cervical intervertebral disc displacement without myelopathy. A note dated 8-5-15 reveals the injured worker presented with complaints of new onset of left hand numbness and tingling. He reports neck, bilateral shoulders, bilateral hand-wrists, right middle finger and low back pain. He also reports difficulty having an erection and loss of bladder control. A physical examination dated 8-5-15 revealed constant low back pain, left anterior thigh, left lateral ankle and left lateral calf are intact to light touch sensation. Prior treatment and therapeutic response was not included. Diagnostic studies to date have included x-rays. A request for authorization dated 8-19-15 for a head MRI with sedation, pain medicine follow up visit, neurology follow up visit, internal medicine follow up visit, neuropsychological testing and psych follow up visit are all non-certified, per Utilization Review letter dated 8-26-15.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI of Head with Sedation: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation 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/MRI.

Decision rationale: The request is for an MRI of the head. The official disability guidelines state the following regarding this topic: 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) Neuro-imaging 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. (Cifu, 2009) See also Diffusion tensor imaging (DTI). 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, an MRI of the head is not supported. This is secondary to poor documentation of physical exam finding which would be consistent with central nervous system pathology after acute injury. Pending receipt of further information explaining the need for the study, the request is not medically necessary.

Pain Medicine Follow up Visit: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (Chronic)/Office Visits.

Decision rationale: The request is for a pain management consultation. The MTUS guidelines do not address this issue specifically. The ODG state the following regarding this topic, Recommended as determined to be medically necessary. Evaluation and management (E&M) outpatient visits to the offices of medical doctor(s) play a critical role in the proper diagnosis and return to function of an injured worker, and they should be encouraged. The need for a clinical office visit with a health care provider is individualized based upon a review of the patient concerns, signs and symptoms, clinical stability, and reasonable physician judgment. The determination is also based on what medications the patient is taking, since some medicines such as opiates, or medicines such as certain antibiotics, require close monitoring. As patient conditions are extremely varied, a set number of office visits per condition cannot be reasonably established. The determination of necessity for an office visit requires individualized case review and assessment, being ever mindful that the best patient outcomes are achieved with eventual patient independence from the health care system through self care as soon as clinically feasible. The ODG Codes for Automated Approval (CAA), designed to automate claims management decision-making, indicates the number of E&M office visits (codes 99201-99285) reflecting the

typical number of E&M encounters for a diagnosis, but this is not intended to limit or cap the number of E&M encounters that are medically necessary for a particular patient. Office visits that exceed the number of office visits listed in the CAA may serve as a "flag" to payors for possible evaluation, however, payors should not automatically deny payment for these if pre-authorization has not been obtained. Note: The high quality medical studies required for treatment guidelines such as ODG provides guidance about specific treatments and diagnostic procedures, but not about the recommended number of E&M office visits. Studies have and are being conducted as to the value of "virtual visits" compared with inpatient visits, however the value of patient/doctor interventions has not been questioned. (Dixon, 2008) (Wallace, 2004) Further, ODG does provide guidance for therapeutic office visits not included among the E&M codes, for example Chiropractic manipulation and Physical/Occupational therapy. See also Telehealth. In this case, the request is not supported by the documentation. There are no records reflecting the reasoning for the visit or evaluation. As such, the request is not medically necessary.

Neurology Follow up Visit: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (chronic)/Office visits.

Decision rationale: The request is for a specialty consultation. The MTUS guidelines are silent regarding this issue. The ODG state the following: Recommended as determined to be medically necessary. Evaluation and management (E&M) outpatient visits to the offices of medical doctor(s) play a critical role in the proper diagnosis and return to function of an injured worker, and they should be encouraged. The need for a clinical office visit with a health care provider is individualized based upon a review of the patient concerns, signs and symptoms, clinical stability, and reasonable physician judgment. The determination is also based on what medications the patient is taking, since some medicines such as opiates, or medicines such as certain antibiotics, require close monitoring. As patient conditions are extremely varied, a set number of office visits per condition cannot be reasonably established. The determination of necessity for an office visit requires individualized case review and assessment, being ever mindful that the best patient outcomes are achieved with eventual patient independence from the health care system through self care as soon as clinically feasible. The ODG Codes for Automated Approval (CAA), designed to automate claims management decision-making, indicates the number of E&M office visits (codes 99201-99285) reflecting the typical number of E&M encounters for a diagnosis, but this is not intended to limit or cap the number of E&M encounters that are medically necessary for a particular patient. Office visits that exceed the number of office visits listed in the CAA may serve as a "flag" to payors for possible evaluation, however, payors should not automatically deny payment for these if pre-authorization has not been obtained. Note: The high quality medical studies required for treatment guidelines such as ODG provides guidance about specific treatments and diagnostic procedures, but not about the recommended number of E&M office visits. Studies have and are being conducted as to the value of "virtual visits" compared with inpatient visits, however the value of patient/doctor interventions has not been questioned. (Dixon, 2008) (Wallace, 2004) Further, ODG does provide guidance for therapeutic office visits not included among the E&M codes, for example Chiropractic manipulation and Physical/Occupational therapy. See also Telehealth. In this case, the request is not medically necessary. This is secondary to poor documentation as to the

reasoning for the visit and consultation. There is inadequate discussion of the specific issue requiring further evaluation and assessment.

Internal Medicine Follow up Visit: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (chronic)/Office visits.

Decision rationale: The request is for a specialty consultation. The MTUS guidelines are silent regarding this issue. The ODG state the following: Recommended as determined to be medically necessary. Evaluation and management (E&M) outpatient visits to the offices of medical doctor(s) play a critical role in the proper diagnosis and return to function of an injured worker, and they should be encouraged. The need for a clinical office visit with a health care provider is individualized based upon a review of the patient concerns, signs and symptoms, clinical stability, and reasonable physician judgment. The determination is also based on what medications the patient is taking, since some medicines such as opiates, or medicines such as certain antibiotics, require close monitoring. As patient conditions are extremely varied, a set number of office visits per condition cannot be reasonably established. The determination of necessity for an office visit requires individualized case review and assessment, being ever mindful that the best patient outcomes are achieved with eventual patient independence from the health care system through self care as soon as clinically feasible. The ODG Codes for Automated Approval (CAA), designed to automate claims management decision-making, indicates the number of E&M office visits (codes 99201-99285) reflecting the typical number of E&M encounters for a diagnosis, but this is not intended to limit or cap the number of E&M encounters that are medically necessary for a particular patient. Office visits that exceed the number of office visits listed in the CAA may serve as a "flag" to payors for possible evaluation, however, payors should not automatically deny payment for these if preauthorization has not been obtained. Note: The high quality medical studies required for treatment guidelines such as ODG provides guidance about specific treatments and diagnostic procedures, but not about the recommended number of E&M office visits. Studies have and are being conducted as to the value of "virtual visits" compared with inpatient visits, however the value of patient/doctor interventions has not been questioned. (Dixon, 2008) (Wallace, 2004) Further, ODG does provide guidance for therapeutic office visits not included among the E&M codes, for example Chiropractic manipulation and Physical/Occupational therapy. See also Telehealth. In this case, the request is not medically necessary. This is secondary to poor documentation as to the reasoning for the visit and consultation. There is inadequate discussion of the specific issue requiring further evaluation and assessment.

Neuropsychological Testing: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation 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/Neuropsychological testing.

Decision rationale: The request is for a neuropsychological evaluation. The MTUS guidelines are silent regarding this issue. The Official Disability Guidelines state the following regarding this topic: 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 Neuropsychological 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) In this case, neuropsychological testing is not supported by the guidelines. There are no records explaining the need for this testing. As such, the request is not medically necessary.

Psych Follow up visit: Upheld

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

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

Decision rationale: The request is for an evaluation by a psychologist due to persistent pain. The official disability guidelines state the following regarding this topic: Recommended based upon a clinical impression of psychological condition that impacts recovery, participation in

rehabilitation, or prior to specified interventions (e.g., lumbar spine fusion, spinal cord stimulator, implantable drug-delivery systems). (Doleys, 2003) Psychological evaluations are generally accepted, well-established diagnostic procedures not only with selected use in pain problems, but also with more widespread use in subacute and chronic pain populations. Diagnostic evaluations should distinguish between conditions that are preexisting, aggravated by the current injury or work related. Psychosocial evaluations should determine if further psychosocial interventions are indicated. The interpretations of the evaluation should provide clinicians with a better understanding of the patient in their social environment, thus allowing for more effective rehabilitation. (Main-BMJ, 2002) (Colorado, 2002) (Gatchel, 1995) (Gatchel, 1999) (Gatchel, 2004) (Gatchel, 2005) For the evaluation and prediction of patients who have a high likelihood of developing chronic pain, a study of patients who were administered a standard battery psychological assessment test found that there is a psychosocial disability variable that is associated with those injured workers who are likely to develop chronic disability problems. (Gatchel, 1999) Childhood abuse and other past traumatic events were also found to be predictors of chronic pain patients. (Goldberg, 1999) Another trial found that it appears to be feasible to identify patients with high levels of risk of chronic pain and to subsequently lower the risk for work disability by administering a cognitive-behavioral intervention focusing on psychological aspects of the pain problem. (Linton, 2002) Other studies and reviews support these theories. (Perez, 2001) (Pulliam, 2001) (Severeijns, 2001) (Sommer, 1998) In a large RCT the benefits of improved depression care (antidepressant medications and/or psychotherapy) extended beyond reduced depressive symptoms and included decreased pain as well as improved functional status. (Lin-JAMA, 2003) See "Psychological Tests Commonly Used in the Assessment of Chronic Pain Patients" from the Colorado Division of Workers Compensation, which describes and evaluates the following 26 tests: (1) BHI 2nd ed., Battery for Health Improvement, (2) MBHI - Millon Behavioral Health Inventory [has been superseded by the MBMD following, which should be administered instead], (3) MBMD - Millon Behavioral Medical Diagnostic, (4) PAB - Pain Assessment Battery, (5) MCMI-111 - Millon Clinical Multiaxial Inventory, (6) MMPI-2 - Minnesota Inventory, (7) PAI - Personality Assessment Inventory, (8) BBHI 2 - Brief Battery for Health Improvement, (9) MPI - Multidimensional Pain Inventory, (10) P-3 - Pain Patient Profile, (11) Pain Presentation Inventory, (12) PRIME-MD - Primary Care Evaluation for Mental Disorders, (13) PHQ - Patient Health Questionnaire, (14) SF 36, (15) SIP - Sickness Impact Profile, (16) BSI - Brief Symptom Inventory, (17) BSI 18 - Brief Symptom Inventory, (18) SCL-90 - Symptom Checklist, (19) BDI-II - Beck Depression Inventory, (20) CES-D - Center for Epidemiological Studies Depression Scale, (21) PDS - Post Traumatic Stress Diagnostic Scale, (22) Zung Depression Inventory, (23) MPQ - McGill Pain Questionnaire, (24) MPQ-SF - McGill Pain Questionnaire Short Form, (25) Oswestry Disability Questionnaire, (26) Visual Analogue Pain Scale - VAS. (Bruns, 2001) Chronic pain may harm the brain, based on using functional magnetic resonance imaging (fMRI), whereby investigators found individuals with chronic back pain (CBP) had alterations in the functional connectivity of their cortical regions - areas of the brain that are unrelated to pain - compared with healthy controls. Conditions such as depression, anxiety , sleep disturbances, and decision-making difficulties, which affect the quality of life of chronic pain patients as much as the pain itself, may be directly related to altered brain function as a result of chronic pain. (Baliki, 2008) Maladjusted childhood behavior is associated with the likelihood of chronic widespread pain in adulthood. (Pang, 2010) Psychosocial factors may predict persistent pain after acute orthopedic trauma, according to a recent study. The early identification of those at risk of ongoing pain is of particular importance for injured workers and compensation systems. Significant independent predictors of pain outcomes were high levels of initial pain, external attributions of responsibility for the injury, and psychological distress. Pain-related work disability was also significantly predicted by poor recovery expectations, and pain severity was significantly predicted by being injured at

work. (Clay, 2010) See also Comorbid psychiatric disorders. See also the Stress/Mental Chapter. In this case, the request is not supported by the documentation. There are no records explaining the need for the visit. As such, the request is not medically necessary.