

Case Number:	CM15-0194569		
Date Assigned:	10/08/2015	Date of Injury:	07/29/2015
Decision Date:	11/24/2015	UR Denial Date:	09/09/2015
Priority:	Standard	Application Received:	10/05/2015

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: California, Arizona, Maryland
Certification(s)/Specialty: Psychiatry

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 is a 56-year-old female with a date of industrial injury 7-29-2015. The medical record indicated the injured worker (IW) fell and was treated for neck sprain-strain and memory loss. In the progress notes (8-25-15), the IW reported intermittent headaches occurring two to three times a day; dizziness (not vertigo), which was intermittent; occasional blurred vision; memory and thought issues; neck and low back pain; numbness and tingling; and irritability. She stated she had a history of seizure disorder since age 16, usually occurring in her sleep. Medications included Phenobarbital, Keppra, Meloxicam and Lidoderm patches for leg pain. On examination (8-25-15 notes), she was alert and oriented to all spheres. She had difficulty following simple commands. Remembering four unrelated words required cueing at three and five minutes. Cranial nerves I through XII was grossly intact. Muscle strength was normal in the upper and lower extremities without atrophy, fasciculation or drift. There was no focal asymmetry. It was difficult to determine if she had a glove-and-stocking neuropathy. There was marked slowness of movement and coordination on finger-to-nose testing, palm-and-dorsum and on following simple commands. She fell off the line on tandem gait, but then performed tandem gait fine, but slightly exaggerated. Treatments included physical therapy, which was moderately helpful, chiropractic therapy and medications (Tylenol with codeine). A Request for Authorization dated 9-2-15 was received for an organic neuropsychology exam. The Utilization Review on 9-9-15 non-certified the request for an organic neuropsychology exam.

IMR ISSUES, DECISIONS AND RATIONALES

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

Organic neuropsych exam: 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 Chapter, Neuropsychological testing.

MAXIMUS guideline: Decision based on MTUS Stress-Related Conditions 2004, Section(s): Diagnostic Testing. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Head/ Neuropsychological testing.

Decision rationale: AECOM guidelines state: Consider specialty referral if persistent symptoms are not consistent with clinical findings. In general, neuropsychological testing is not indicated early in the diagnostic evaluation. Rather, it is most useful in assessing functional status or determining workplace accommodations in individuals with stable cognitive deficits. Per ODG, 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. The submitted documentation lists the diagnosis of neck sprain-strain and memory loss; however the examination does not suggest psychological disorders or neurologic dysfunction/cognitive disorders associated with the brain. There is no history of traumatic brain injury or concussions. The request for Organic neuropsych exam is not medically necessary based on the clinical findings.