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| Case Number: | CM15-0195245 | | |
| Date Assigned: | 10/09/2015 | Date of Injury: | 12/15/2014 |
| Decision Date: | 11/25/2015 | UR Denial Date: | 09/21/2015 |
| 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: Texas, New York, 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:

The applicant is a represented [REDACTED] beneficiary who has filed a claim for chronic neck pain reportedly associated with an industrial injury of December 15, 2014. In a Utilization Review report dated September 24, 2015, the claims administrator failed to approve a request for videonystagmography (VNG) testing. The claims administrator referenced an August 11, 2015 office visit in its determination. The applicant's attorney subsequently appealed. On said August 11, 2015 office visit, the applicant reported ongoing complaints of neck and mid back pain, highly variable, 7-9/10. The applicant was on naproxen and Flexeril, it was reported. The applicant was pending receipt of a cervical epidural steroid injection, it was reported. The applicant was given diagnoses of chronic neck pain, cervical degenerative disk disease, cervical foraminal stenosis, tinnitus, and posttraumatic headaches. EEG testing, a sleep study, audiology testing, and videonystagmogram (VNG) were endorsed. Little-to-no rationale accompanied these request(s). Cervical epidural steroid injection was sought. The attending provider suggested (but did not clearly state) that the claimant would remain off of work as his employer was unable to accommodate suggested limitations. The applicant's gait was not characterized in the clinic.

IMR ISSUES, DECISIONS AND RATIONALES

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

Videonystagmography (VNG) testing: 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, Vestibular studies.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation <http://emedicine.medscape.com/article/2149881-workup#c12> Dizziness, Vertigo, and Imbalance Workup Author: Hesham M Samy, MD, PhD; Chief Editor: Robert A Egan, MD Such testing, especially vestibular testing, must be tailored to the history and physical findings in each case. Routine use of diagnostic imaging modalities in the assessment of patients with dizziness is not recommended.[9] It should be kept in mind that the results of audiometry and vestibular testing are not diagnostic in the medical sense. The most commonly performed vestibular tests are as follows: Electro/videonystagmography (ENG) The rotating-chair test, also referred to as sinusoidal harmonic acceleration (SHA) Computerized dynamic posturography (CDP) Vestibular evoked myogenic potentials Second, overinterpretation of oculomotor findings is common, leading to unnecessary neurologic investigations, especially MRI; in the database, the yield for abnormalities of central eye movements, saccadic dysmetria, saccadic pursuit, asymmetric optokinetic response, and gaze-evoked nystagmus was less than 5%; Finally, most abnormalities detected by vestibular testing can be identified by means of a carefully conducted office vestibular examination.

Decision rationale: No, the request for videonystagmography was not medically necessary, medically appropriate, or indicated here. The MTUS does not address the topic. However, Medscape's Dizziness, Vertigo, and Imbalance article notes that vestibular testing "must be tailored to the history and physical findings in each case." Medscape notes that the routine usage of diagnostic modalities in assessment of claimants with dizziness is "not recommended," citing the low yield of vestibular testing. Here, little-to-no narrative commentary accompanied the August 11, 2015 request. The fact that EEG testing, a sleep study, audiology testing, and videonystagmography were all concurrently ordered strongly suggested that these studies were in fact being ordered on a routine basis, without any clearly formed intention of acting on the results of the same. The attending provider did not seemingly tailor the history and physical therapy exam findings to the request for vestibular testing. The claimant's gait was not described or characterized on August 11, 2015. The extent, magnitude, severity, and/or scope of the claimant's issues with dizziness (if any) was likewise not clearly described or characterized on the August 11, 2015 office visit at issue. Therefore, the request was not medically necessary.