

Case Number:	CM15-0197487		
Date Assigned:	10/12/2015	Date of Injury:	05/29/2009
Decision Date:	11/30/2015	UR Denial Date:	09/18/2015
Priority:	Standard	Application Received:	10/07/2015

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 headaches reportedly associated with an industrial injury of May 29, 2009. In a Utilization Review report dated September 18, 2015, the claims administrator failed to approve a request for CT imaging of the brain (head). A September 3, 2015 office visit was referenced in the determination. The claims administrator stated that the claimant had a history of globoid lesion about the frontal lobe status post earlier craniectomy of the same. The applicant's attorney subsequently appealed. On a September 3, 2015 appeal letter, the treating provider sought authorization for a CT scan of the head apparently performed in October 2014. It was stated that the applicant had a history of recurrent headaches, brain bleeding, and a tumor resulting in symptoms to include headaches, dizziness, nausea, and vomiting. It was stated that the applicant was hospitalized during the dates in question. In a hospitalization discharge summary dated October 24, 2015, it was acknowledged that the applicant was discharged with diagnoses to include COPD, anxiety, depression, headaches, nausea, vomiting, and enlarging cavernoma. CT imaging was apparently performed during the admission and apparently did not demonstrate a significant interval change in the claimant's prior admission. On an admission history and physical dated October 11, 2014, it was stated that the applicant was admitted with an operating diagnosis of encephalopathy. CT imaging of the head performed demonstrated a 1.5-cm hyperintense lesion about the right frontal lobe, most likely tumorous in nature. The applicant was status post earlier frontal craniotomy, it was reported.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective CT (computed tomography) scan of the brain (unspecified DOS): 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 7/24/2015) Online Version, CT (computed tomography).

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

Decision rationale: Yes, the retrospective request for CT imaging of the brain performed in October 2014 was medically necessary, medically appropriate, and indicated here. The MTUS does not address the topic. However, ODGs Head Chapter CT Imaging topic notes that CT scans are generally accepted when there is a suspected intracranial bleed, altered mental status or any changes in the claimant's clinical presentation, including development of new neurologic symptoms or in claimants who present to the emergency department with headaches and abnormal findings. Here, the claimant was apparently hospitalized between the dates October 16, 2014 through October 21, 2014 with symptoms to include headaches, nausea, and vomiting. The claimant had a history of previously operated upon brain tumor. Obtaining CT imaging was indicated to determine a source of the claimant's new-onset symptoms and/or the basis for the claimant's admission. An intracranial bleed and/or recurrent tumor were on the differential diagnosis list, it was suggested on an appeal letter dated September 3, 2015. The CT imaging in question was indicated, given the fact that the claimant's symptoms were so severe as to require a 5- to 6-day admission. Therefore, the request was medically necessary.