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| Case Number: | CM15-0203149 | | |
| Date Assigned: | 10/19/2015 | Date of Injury: | 05/02/2012 |
| Decision Date: | 12/02/2015 | UR Denial Date: | 10/01/2015 |
| Priority: | Standard | Application Received: | 10/15/2015 |

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: Family Practice

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 62-year-old male, who sustained an industrial-work injury on 5-2-12. A review of the medical records indicates that the injured worker is undergoing treatment for traumatic brain injury, cognitive disorder and post concussive disorder. Medical records dated 9-21-15 indicate that the injured worker complains of cognitive symptoms such as slowed thinking, difficulty with concentration, reading and writing difficulties and moderate mental confusion. He also has psychiatric symptoms such as severe sleep disturbance, irritability, overwhelmed by stress, chronic fatigue, depression, worry, crying and thoughts of suicide. He also has pain symptoms. Per the treating physician, report dated 9-21-15 the injured worker has not returned to work. The mental exam dated 9-21-15 reveals stable mood and affect is dysphoric. The speech was intelligible. His thoughts were appropriate and disorganized. The verbal expression was moderate impairment due to paraphasias and word finding errors. His verbal reception was mildly impaired because of what appears to be either hearing or attention difficulties. His cognitive speed was within normal limits. His memory of personal information was, at times, vague and other times, disorganized because of word finding difficulties. The physician indicates that he requires the treatment of a speech pathologist to provide training in mediation skills for cognitive weakness and errors. The cognitive re-training progress report dated 8-31-15 reveals that he continues to struggle with speech problems including word finding and forming complete sentences. His processing speed remains very slow. Treatment to date has included pain medication, cognitive retraining at least 3 sessions, neuropsychological evaluation, and other modalities. The request for authorization date was 9-21-15 and requested service included Speech therapy sessions qty: 8. The original Utilization review dated 10-1-15 non-certified the request for Speech therapy sessions qty: 8.

IMR ISSUES, DECISIONS AND RATIONALES

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

Speech therapy sessions qty: 8: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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, Speech Therapy.

Decision rationale: This patient is a 62-year-old man who receives treatment for an industrial injury that occurred on 05/02/2012. The patient receives treatment for chronic pain syndrome, expressive speech disorder, chronic fatigue, major depression, recurring headaches, and the patient has become opioid dependent. The medications of the patient include Oxycontin 20 mg, 2 or 3x a day, Norco, Flexiril, and Celexa. The side effects of the patient's two opioids (Oxycontin and hydrocodone) and the muscle relaxer (Flexiril) include sedation, confusion, and fatigue. When used in combination these side effects are more likely. The patient's medical records state that the patient has received authorization for 24 speech therapy sessions. The documentation is not clear on the degree of progress the patient has achieved, or a clear statement of what the functional goal is supposed to be. In the ODG treating guidelines for speech disorders, the clinician must show that the patient has a problem with speech from either a traumatic event or a medical disorder that creates a functional speech deficit. While the patient did suffer from a traumatic brain injury back in 2012 that appears to have caused a problem in word finding and fluent speech, there is now a very real likelihood that the current medication treatment regime is contributing to the patient's cognitive dysfunction and difficulty with word finding that must be addressed. In sum, the patient's polypharmacy may be clouding this patient's sensorium and this must be addressed before additional speech therapy is medically indicated. Therefore, the request is not medically necessary.