MAXIMUS Federal Services

Case Number:	CM15-0207580		
Date Assigned:	10/26/2015	Date of Injury:	05/24/2014
Decision Date:	12/09/2015	UR Denial Date:	10/13/2015
Priority:	Standard	Application Received:	10/22/2015

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: Physical Medicine & Rehabilitation

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 injured worker is a 34 year old male who reported an industrial injury on 5-24-2014. His diagnoses, and or impressions, were noted to include: a catastrophic roll-over motor vehicle accident with significant head injury and extensive loss of consciousness, and severe mangling injury to the left leg and a left above-the-knee amputation (6-6-14); chronic pain syndrome; and cognitive impairments affecting learning and-or compliance. No imaging studies were noted. His treatments were noted to include: a neuropsychological consult on 6-18-2014, and neuropsychological evaluation and testing on 8-31-2015; prosthesis and physical therapy; and rest from work. The neuropsychological consult notes of 8-31-2015 reported: that on a qualitative basis, very mild impairment in verbal working memory was present, and that he performed poorly on a task requiring him to form and alter a cognitive set. The physician's requests for treatment were not noted to include a strong recommendation for ongoing psychotherapeutic support, and that he would benefit from some degree of speech and language therapy in an effort to assist in coping techniques and allowing him to move efficiently, categorize information that may assist with cognitive performance. No Request for Authorization was noted in them medical records provided. The Utilization Review of 10-6-2015 modified the request for 6 speech therapy sessions, to a speech therapy evaluation. The progress notes of 4-15-2015 noted some cognitive memory issues, and the request for authorization dated 4-21-2015 noted a request for psychological evaluation for neuropsychological testing. A request for authorization dated 6-12-2015 was noted for neuropsychological testing due to adjustment disorder with mixed anxiety and depressed mood,

rule-out cognitive impairment. The pain psychology progress report of 6-3-2015 noted: a clinical interview on 5-21-2015 & 6-3-2015; a low score on the Montreal Cognitive Assessment, with some difficulty being with language, and that English was his second language; and that more intensive neuropsychological testing be done to rule-out possible organic causes of his memory lapses, considering language appropriate tests.

IMR ISSUES, DECISIONS AND RATIONALES

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

6 speech therapy sessions: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Head Chapter, Speech therapy.

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, under Speech Therapy.

Decision rationale: The patient presents on 09/24/15 with improving left lower extremity symptoms. The patient's date of injury is 05/24/14. The request is for 6 SPEECH THERAPY SESSIONS. The RFA is dated 09/24/15. Physical examination dated 09/24/15 reveals that the patient presents with an antalgic gait with a prosthetic left lower extremity. No other remarkable examination findings are included. The patient is currently prescribed Gabapentin, Lidoderm, and Oxycodone. Patient is currently described as "not fit for duty." Official Disability Guidelines, Head Chapter, under Speech Therapy (ST) states: Recommended as indicated below. Criteria for Speech Therapy are: A diagnosis of a speech, hearing, or language disorder resulting from injury, trauma, or a medically based illness or disease; Clinically documented functional speech disorder resulting in an inability to perform at the previous functional level; Documentation supports an expectation by the prescribing physician that measurable improvement is anticipated in 4-6 months; The level and complexity of the services requested can only be rendered safely and effectively by a licensed speech and language pathologist or audiologist; Treatment beyond 30 visits requires authorization. In regard to the 6 sessions of speech therapy for this patient's documented speech deficits, the request is appropriate. Progress note dated 09/24/15 indicates that this patient underwent neuropsychological testing on 08/31/15 which showed evidence of a mild impairment in working memory. The neuropsychological consult has the following regarding recommendations for care: "The patient may benefit from some degree of speech and language therapy in an effort to assist in coping techniques and allowing him to more efficiently categorize information that may assist cognitive performance." In this case, given the neuropsychological evaluation with evidence of ongoing speech impairment, a series of 6 speech therapy visits is an appropriate measure and could produce benefits for this patient. Therefore, the request IS medically necessary.