

Case Number:	CM15-0222652		
Date Assigned:	11/18/2015	Date of Injury:	09/24/2014
Decision Date:	12/30/2015	UR Denial Date:	10/23/2015
Priority:	Standard	Application Received:	11/12/2015

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: Psychologist

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 56 year old male who sustained an industrial injury on 9-24-2014. Medical records indicate the injured worker is being treated for status post exposure to chemicals in the work place, muscle contraction and vascular headache, lumbar spine strain-sprain rule out radiculitis-radiculopathy right greater than left secondary to herniated lumbar disc with spondylolisthesis L4-5 with herniated lumbar disc with facet arthrosis L4-L5, L5-S1, and posttraumatic stress disorder. Per the neurological initial evaluation and re-evaluation notes dated 9-15-2015 and 10-27-2015 the injured worker reports some headaches but mostly numbness at the back of his head, his right hand shakes when using a tablet, he loses track of his thoughts in conversation, he feels tenderness in the back of his head that is constant, and he has dizziness and drowsiness and is lightheaded when he gets up in the morning. The injured worker reports his headaches occur approximately 3-4 times a week and are located at the back of his head and last for approximately 30 minutes. He also reports a loss of smell and hearing and notices sensitivity to light. The injured worker also reports a burning pain in his throat caused by chemical exposure. The injured worker is currently taking Tramadol once a day for low back pain. Per the physical exam on 10-27-2015 the injured worker had tenderness over the scalp to palpation and over the temple regions bilaterally. His cranial nerve examination was within normal limits including visual fields and fundoscopic examination. The treating physician states the headaches appear to be tension related and not due to any specific intracranial pathology and the injured worker is complaining of neck pain that does not appear to be industrial in nature so neuropsychometric testing is recommended to determine the exact degree in nature of his

cognitive impairment. The injured worker is temporarily totally disabled from 10-27-2015 to 12-11-2015. Per the treating physician's report on 10-16-2015, the injured worker reports pain in his lower back with radicular symptoms into his legs. He rates his pain at a 9 out of 10 and the pain intermittently wakes him up at night. The injured worker reports his symptoms are aggravated with prolonged sitting, standing, and walking. Per the physical examination on 10-16-2015 the injured worker has tightness and spasm in the lumbar paraspinal musculature bilaterally and has weakness with big toe dorsiflexion and plantar flexion bilaterally. The EMG report dated 9-10-2015 states it is an abnormal EMG of the lower extremities suggesting the presence of a lumbosacral radiculopathy, acute and chronic in nature, primarily involving L4-5 nerve roots. The nerve conduction velocity study of the lower extremities dated 9-15-2015 is abnormal due to slow conduction between knee and ankle involving the major nerves of the lower extremities and the findings suggest an underlying peripheral polyneuropathy, axonal in type. Treatment to date for the injured worker includes rest, home exercises, physiotherapy, medications, Fexmid 7.5mg, Ultracet 37.5/325mg, Voltaren XR 100mg, and Prilosec 20mg. A referral for authorization was submitted on 9-15-2015 for neuropsychometric testing. The UR decision dated 10-23-2015 non-certified this request.

IMR ISSUES, DECISIONS AND RATIONALES

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

Neuropsychometric Testing: Overturned

Claims Administrator guideline: Decision based on MTUS Stress-Related Conditions 2004. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Head Chapter, neuropsychological testing.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Psychological evaluations. Decision based on Non-MTUS Citation Official disability guidelines, Chapter Head, topic: Neuropsychological testing. August 2015 update.

Decision rationale: Citation Summary 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. Attention, memory, and executive functioning deficits after TBI can be improved using interventions emphasizing strategy training (i.e., training patients to compensate for residual deficits, rather than attempting to eliminate the underlying neurocognitive impairment) including use of assistive technology or memory aids. (Cifu, 2009) Neuropsychological testing is one of the cornerstones of concussion and traumatic brain injury

evaluation and contributes significantly to both understanding of the injury and management of the individual. The application of neuropsychological (NP) testing in concussion has been shown to be of clinical value and contributes significant information in concussion evaluation, but NP assessment should not be the sole basis of management decisions. Formal NP testing is not required for all athletes, but when it is considered necessary, it should be performed by a trained neuropsychologist. A request was made for neuropsychometric testing, the request was non-certified by utilization review provided the following rationale for its decision: "within the medical information available for review, despite documentation of the request for a formal neuropsychometric test to determine the exact degree of nature of the patient's sleep disorder and headaches, there is no documentation of severe brain injury or concussion or mild traumatic brain injury with symptoms persisting beyond 30 days and testing not to exceed 15 hours. Therefore, certification of the requested neuropsychometric testing is not recommended." This IMR will address a request to overturn the utilization review decision. All the provided medical records were carefully considered for this IMR and consisted of approximately 175 pages. The medical records reflect that the patient was exposed to a muriatic chemical when the pressure of a gasoline tank is containing the acid popped open with the chemical covering his face and hair making it difficult for him to breathe because of the chemical. The utilization review rationale for non-certification of the request is based on the idea that he did not suffer a blunt head trauma injury. In this case the reported exposure to chemicals may have created a comparable neurotoxic event for the patient. The patient has been momentarily evaluated by neurology and a clear rationale for the requested neuropsychometric testing was detailed in the provided medical records. The patient remains symptomatic at a clinically significant level, and the patient exhibits delayed recovery. This request was found to be medically necessary, appropriate and reasonable and therefore the utilization review decision is overturned.