

Case Number:	CM15-0041327		
Date Assigned:	03/11/2015	Date of Injury:	02/17/2011
Decision Date:	04/21/2015	UR Denial Date:	02/26/2015
Priority:	Standard	Application Received:	03/04/2015

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: Indiana

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 injured worker is a 30-year-old female, who sustained an industrial injury on 2/17/2011. She reported striking her head against a hard box. The injured worker was diagnosed as having head injury, unspecified, frontal lobe syndrome, and post concussion syndrome. Treatment to date has included conservative measures. Currently, the injured worker complains of continued migraines and sharp head pains. She reported hypersensitivity to light and noise and admitted to balance impairment and vertigo, causing nausea. She also reported neck and bilateral shoulder pain, rated 7/10. Physical exam noted scotopic hypersensitivity and mild unsteadiness of gait, and had been using a service dog for her balance. Normal strength and sensation was noted to all extremities. Cranial nerves 2-12 were intact. It was documented that she was undergoing balance therapy and vision therapy, with additional treatments requested, along with musician's earplugs for auditory hypersensitivity. A neuro-psychomotor progress note from 12/01/2014 was referenced, noting recommendation for treatment as including outpatient rehabilitation program. Current medications were not noted. A computerized tomography of the head was reported to be normal.

IMR ISSUES, DECISIONS AND RATIONALES

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

12 sessions of balance therapy over the next 12 weeks: Upheld

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

MAXIMUS guideline: Decision based on Non-MTUS Citation Official Disability Guidelines (ODG); Head; Vestibular PT.

Decision rationale: Regarding balance therapy, MTUS is silent, but ODG states the following, "Recommended for patients with vestibular complaints (dizziness and balance dysfunction), such as with mTBI/concussion. Vestibular rehabilitation has been shown to be associated with improvements in independence and dynamic visual acuity. (Cohen, 2006) Vestibular rehabilitation should be considered in the management of individuals post concussion with dizziness and gait and balance dysfunction that do not resolve with rest. (Alsalaheen, 2010) Vestibular complaints are the most frequent sequelae of mTBI, and vestibular physical therapy has been established as the most important treatment modality for this group of patients. (Gottshall, 2011) The use of vestibular rehabilitation for persons with balance and vestibular disorders improves function and decreases dizziness symptoms. (Whitney, 2011) A 6-month physical therapist-prescribed balance and strength home exercise program, based on the Otago Exercise Program and the Visual Health Information Balance and Vestibular Exercise Kit, significantly improved outcomes relative to the control group. (Yang, 2012) Patients with vestibular symptoms after concussion may have slower reaction times, putting them at risk for new injury compared with those who have concussions without these symptoms. A patient who is identified as having a convergence insufficiency should be prescribed in-office and home-based vision therapy designed to improve this visual deficit. In contrast, a patient identified as having predominately dizziness-related vestibular impairment from post-traumatic migraine or cervicogenic factors might be targeted with specific medications for migraine symptoms or physical therapy if it is neck-related."The employee had a milder injury than delineated in the guidelines above to warrant balance therapy, and there is no documentation on functional improvements from previous sessions and the goals for the new ones. Therefore, the request is not medically necessary.

6 sessions of vision therapy over the next 12 weeks: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation url: www.ncbi.nlm.nih.gov/pubmed/12498561.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Aetna Clinical Policy Bulletins: Vision Therapy.

Decision rationale: MTUS and ODG are silent on vision therapy, but Aetna states the following "Aetna considers up to 12 vision therapy visits or sessions medically necessary for treatment of convergence insufficiency. Aetna considers vision therapy experimental and investigational for all other indications. Requests for vision therapy exceeding 12 visits for this indication is subject to medical review. Members should be transitioned to a home program of exercises for convergence insufficiency (e.g., pencil push-ups)."The employee does not have convergence insufficiency, and there is no justification as to why an experimental therapy should be

continued. There is no documentation of current functional benefit from prior sessions. Therefore, the request is not medically necessary.

Ear plugs for both ears (two sets): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Hearing protection.

MAXIMUS guideline: Decision based on Non-MTUS Citation Official Disability Guidelines (ODG); Head, Hearing Protection.

Decision rationale: Regarding earplugs and hearing protection, MTUS is silent but ODG states the following "Recommend interventions to improve the use of hearing protection devices. The evidence found in this review shows that some interventions improve the mean use of hearing protection devices compared to non-intervention. A tailored strategy (the use of communication or other types of interventions that are specific to an individual or a group and aim to change behavior) showed an improvement in hearing protective devices (HPDs) use of 8.3% versus education at 6.1%." "There is no documentation or justification as to why the specific musician earplugs would be superior to regular earplugs. Therefore, the request is not medically necessary.

Treatment at outpatient treatment program for 12 weeks of cognitive rehabilitation:
Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Behavioral Interventions Page(s): 23. Decision based on Non-MTUS Citation Official Disability Guidelines, Cognitive Behavioral Therapy guidelines for chronic pain.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Psychological Evaluation Page(s): 100-102. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Psychological treatment, Cognitive Behavioral Therapy (CBT).

Decision rationale: MTUS Pain guidelines and ODG refer to cognitive behavioral psychotherapy as "Recommended for appropriately identified patients during treatment for chronic pain". MTUS details that "Cognitive behavioral therapy and self-regulatory treatments have been found to be particularly effective. Psychological treatment incorporated into pain treatment has been found to have a positive short-term effect on pain interference and long-term effect on return to work." ODG further states that "Initial therapy for these 'at risk' patients should be physical therapy for exercise instruction, using a cognitive motivational approach to PT. Consider separate psychotherapy CBT referral after 4 weeks if lack of progress from PT alone: Initial trial of 3-4 psychotherapy visits over 2 weeks. With evidence of objective functional improvement, total of up to 6-10 visits over 5-6 weeks (individual sessions)." Medical documents provided to not detail any physical therapy in regards to chronic pain. Even with a failure of physical therapy, the initial trial of CBT is for 4 sessions or additional ongoing sessions

of 6-10 visits. The request for 12 sessions of CBT is far in excess of recommended guidelines. As such, the request is not medically necessary.