

Case Number:	CM15-0083805		
Date Assigned:	05/06/2015	Date of Injury:	05/29/2014
Decision Date:	06/05/2015	UR Denial Date:	04/02/2015
Priority:	Standard	Application Received:	05/01/2015

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: New York

Certification(s)/Specialty: Internal Medicine, Pulmonary Disease

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 (IW) is a 46-year-old female who sustained an industrial injury on 05/29/2014. Diagnoses include right MCA cerebrovascular accident (CVA) versus conversion disorder with history of significant post-traumatic stress disorder (PTSD); left hemiparesis; dysphagia; left facial weakness, left visual field cut, cognitive deficits and PTSD/anxiety/insomnia. Treatment to date has included medications, physical and occupational therapy, psychological counseling and home exercise. An MRI of the brain was negative for CVA or hemorrhage. An x-ray video swallow showed premature spillage of contrast media to the level of the piriform sinuses before swallows were initiated and decreased hyolaryngeal elevation when swallows were initiated. According to the progress notes dated 3/31/15, the IW reported that seeing the psychologist was helpful, she was better able to relax and was using Klonopin only as needed. She was able to walk without her walker, but still had some loss of left peripheral vision, was sometimes coughing due to drinking water and was continuing to get headaches. A request was made for speech therapy two times weekly for six weeks for dysphagia.

IMR ISSUES, DECISIONS AND RATIONALES

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

Speech Therapy 2 times a week for 6 weeks, only for Dysphagia, brain: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Goldman's Cecil Medicine, 24th Edition, 2011.

Decision rationale: The patient is a 46 year old female who had an injury on 05/29/2014. It was unclear if she had a stroke or this was a conversion reaction. The MRI of the brain was negative for a stroke and this would favor a conversion reaction. She has improved with treatment from a psychologist. There are no MTUS, ACOEM or ODG recommendation for this case. A video swallowing exam noted some abnormalities. However, the requested 12 visits of speech therapy for swallowing (dysphagia) a year after the injury is not medically necessary. The types of foods and liquids that would provide the most problem swallowing should be readily noted from the swallowing study (and should be avoided) and speech therapy is not medically necessary.