

<b>Case Number:</b>	CM15-0087601		
<b>Date Assigned:</b>	05/11/2015	<b>Date of Injury:</b>	03/28/2013
<b>Decision Date:</b>	06/11/2015	<b>UR Denial Date:</b>	04/10/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/07/2015

### 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 Jersey, Alabama, California  
 Certification(s)/Specialty: Neurology, Neuromuscular 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 44-year-old male, with a reported date of injury of 03/28/2013. The diagnoses include an unspecified head injury, and post-concussion syndrome. Treatments to date have included physical therapy; MRIs of the brain which suggested subclinical neurological condition of unknown etiology; a computerized tomography (CT) scan of the head on 04/02/2013 with negative findings; electrodiagnostic studies of the lower extremity with normal findings; and oral medication. The progress report dated 03/31/2015 indicates that the injured worker had difficulty focusing and concentrating, and had some lightheadedness. It was noted that he continued to improve, and that the ankle reflexes were absent. His status was temporary total disability. The objective findings include some challenges with complex tasks and bilateral confusion on examination. It was noted that there was positive improvements all around, with increased functionality. The neurological examination showed the ability to follow complex commands, no bilateral confusion, normal abstract reasoning, some challenges with rapid complex tasks, normal motor exam, normal sensation, reduced ability to sense temperature in his feet compared to his hands, and normal coordination. The injured worker had a neuropsychological assessment on 01/06/2015 which showed mild overall improvement. The treating physician requested a neuropsychological assessment. The requesting physician noted that the injured worker may benefit from a psychiatric or tertiary care specialist, and a neuropsychological assessment is the most important issue to resolve this claim.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Neuropsychological assessment:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)- TWC Head Procedure Summary last updated 01/21/2015.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Neuropsychological testing. <http://www.odg-twc.com/index.html>.

**Decision rationale:** According to ODG guidelines, Neuropsychological testing 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 computer-based programs Immediate Postconcussion Assessment and Cognitive Testing (ImPACT), CogSport, Automated Neuropsychological Assessment Metrics (ANAM), Sports Medicine Battery, and HeadMinder may have advantages over paper-and-pencil neuropsychological tests such as the McGill Abbreviated Concussion Evaluation (ACE) and the Standardized Assessment of Concussion (SAC). (Cantu, 2006) 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. Baseline NP testing is not required as an aspect of every assessment, but it may be helpful to add useful information to the overall interpretation of the tests. Persistent symptoms (>10 days) are generally reported in 10-15% of concussions, at which point investigations may include formal neuropsychological testing and conventional neuroimaging to exclude structural pathology. (McCrory, 2013) In cases of multiple concussions/ persistent impairment, professional athletes should be referred for neurologic and neuropsychological assessment, and amateur athletes should have formal neurologic/ cognitive assessment and risk

factor counseling. (Giza, 2013). The patient underwent a neuropsychological evaluation on January 2015 and there is no justification to repeat another evaluation. There is no documentation of change or progression of the patient condition to justify another evaluation. Therefore, the request for Neuropsychological assessment is not medically necessary.