

Case Number:	CM14-0145398		
Date Assigned:	09/12/2014	Date of Injury:	05/04/2007
Decision Date:	12/18/2014	UR Denial Date:	07/30/2014
Priority:	Standard	Application Received:	09/08/2014

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. The expert reviewer is Board Certified in Neurology; has a subspecialty in Clinical Neurophysiology and is licensed to practice in Virginia. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

According to the records made available for review, the patient is a 52 year old with a date of injury of 04 May, 2014. The exact mechanism of the injury is not clarified in the medical record. It is documented in the clinical note dated 24 July, 2014 that the mechanism of injury involved a closed head injury. At the time of request for a review, there is a clinical note dated 24 July, 2014. At this time, the injured worker (IW) complained of upper extremity weakness. There is Reynaud's symptoms in his hands and his feet. There are visual symptoms including diplopia and visual field loss for which the IW is being seen by a Neuro-Ophthalmologist who recommends an EEG and a consult with a Neurologist for potential seizures. The IW is seen by the Neuro-Ophthalmologist for visual framing issues. There is no clarification in the medical record as to clinically what the framing issues are or is there a clinical description of what these visual issues are like. The IW has headaches and treats them with Cambia. There is a clinical note dated 09 May, 2014 which states that the IW is taking Topamax for seizure control. There is no clinical description in the medical record of how these seizures present clinically nor is there a workup for them in the record. There is no statement in the record as to when the last seizure was. There is a clinical exam dated 29 May, 2014 which states that the IW's Neurologic exam is intact and that there is tenderness in the cervical spine at the C5-C6 and C6-C7 region at the site of a prior cervical fusion. There is an MRI C spine dated 10 April, 2014 which showed the IW's prior cervical fusion at the C5-C6 and C6-C7 region. There is bilateral uncovertebral joint arthropathy at C4-C5. There is a 2-3 mm broad based protrusion at C4-C5. At C7-T1, there is a small broad based disk protrusion but no arthrosis. There is a 2-3 mm disk protrusion at T1-T2. There is no documentation in the medical record of an MRI of the brain. According to a clinical note dated 29 May, 2014, the patient carries a diagnosis of cervical disk disease, status post right shoulder arthroscopy with probable internal derangement, lumbar disk bulging L3-L4, L4-L5 and L5-S1

with probable right sacral ileitis. There is another clinical note dated 24 July, 2014 which diagnosis the injured worker with status post closed head injury in 2007, residual visual field loss and reports of diplopia, residual headaches, cognitive decline and a right trigeminal nerve injury.

IMR ISSUES, DECISIONS AND RATIONALES

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

Electroencephalogram: 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 (updated 06/08/14), EEG (neurofeedback)

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Head Injury Chapter, EEG clinical indications

Decision rationale: Official Disability Guidelines states that an EEG is a well-established diagnostic procedure that monitors brain wave activity. The information generated by this procedure includes potential alterations in the brain wave activity such as frequency changes or morphologic changes seen in seizures. The guidelines further state that following an initial assessment and clinical stabilization, that a patient's clinical course should specifically be monitored. In the case of the injured worker described above, there is a statement that the patient has visual framing issues and is seen for these symptoms by a Neuro-Ophthalmologist who recommends a Neurology consult and a workup with an electroencephalogram (EEG). There is no documentation in the records provided that the Neurology consult has occurred. There is no description in the medical record of a specific clinical description of what happens during the IW's symptoms of "visual framing" or why these symptoms may clinically represent seizure. There is no documentation of an MRI brain in the medical record. There is no clinical course of the IW's seizures described in the medical record since the closed head injury in 2007. There is no description of the seizure frequency, last documented seizure, or a statement as to how well the patient is controlled clinically with the use of Topamax. Therefore, based on the guidelines and a review of the evidence, an electroencephalogram is not medically necessary.