

Case Number:	CM14-0145454		
Date Assigned:	09/12/2014	Date of Injury:	05/28/2014
Decision Date:	10/14/2014	UR Denial Date:	08/27/2014
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, this is a 61 year old man who was injured at work on 05/28/2014. He apparently hit his head while working in the kitchen with a period of loss of consciousness. He had a Computed Tomography (CT) head on 05/28/2014 which showed a Subarachnoid Hemorrhage within bilateral frontal lobes and bilateral temporal lobes with hemorrhagic products layering along the tentorium. He was followed closely while in the hospital but was managed medically and not surgically as per clinical note dated 05/28/2014. He was treated with Keppra for seizure prophylaxis. There is no documentation in the medical record that he ever experienced a seizure clinically. The injured worker was sent to a skilled nursing facility as per clinical note dated 06/10/2014. On this date, it was documented that he was alert and interactive and beginning to ambulate. On exam, he knew that it was June, 2014 but was not oriented to place. He was able to follow simple commands on exam on this date. A follow up Computed Tomography (CT) head performed on 06/10/2014 showed resolution of the subarachnoid blood but continued to show edema in the frontal lobes bilaterally. In a clinical note documented on 07/24/2014, the injured worker was seen in follow up in a Neurosurgery clinic. According to this note, the injured worker was documented to be "overall feeling well." He was continuing to recover. He stated that he "felt back to his baseline." His therapist had told him that he did not need therapy anymore. His exam showed normal cranial nerves, fluent speech, full visual fields, normal strength exam and a normal gait exam. A CT head dated 07/24/2014 which documented a decreasing size of low attenuation in the inferior frontal lobes bilaterally at the site of his previous hemorrhagic contusions.

IMR ISSUES, DECISIONS AND RATIONALES

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

Electroencephalogram (while awake): 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) Integrated Treatment/Disability Duration Guidelines, Head Chapter, Indications of Imaging --EEG

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 (encephalography)

Decision rationale: The Official Disability Guideline (ODG) describes an encephalogram (EEG) as a procedure that monitors brain wave activity to measure frequency changes (nonspecific) or morphologic changes (seizures). An EEG is generally not indicated following an immediate period of emergency response, evaluation and treatment. Following an initial assessment, and stabilization, the individual's course could be monitored. According to the guidelines, if there is failure to improve or if additional deterioration following the initial assessment stabilization, an EEG may aid in the diagnostic evaluation. In the case of the injured worker, the clinical course continued to improve steadily over a period of time. At no time was there documentation of a clinical seizure or of a clinical deterioration or failure to improve clinically. The clinical note dated 07/24/2014 stated that the injured worker felt back to his baseline and that he was no longer in need of therapy. Therefore, based on the guidelines and a review of the evidence, the request for an Electroencephalogram (while awake) is not medically necessary.