

Case Number:	CM14-0161616		
Date Assigned:	10/07/2014	Date of Injury:	10/13/2013
Decision Date:	11/04/2014	UR Denial Date:	09/09/2014
Priority:	Standard	Application Received:	10/01/2014

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 Psychology and is licensed to practice in California. 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:

The claimant is a 40 year-old female [REDACTED] with a date of injury of 10/13/13. The claimant sustained injury when she slipped and fell, landing on her back and striking her head. The claimant sustained this injury while working as a housekeeper for [REDACTED]. In his "Supplemental Agreed Medical Evaluation Report" dated 9/4/14, [REDACTED] diagnosed the claimant with: (1) Head trauma with post concussive syndrome including headaches and nausea, resolving; (2) Right cervicothoracic strain with right upper extremity cervical radiculopathy; (3) Right shoulder impingement syndrome; (4) Contusion, right elbow; (5) Degenerative disc disease at L4-L5 with annular fissure and 2-3mm posterior disc protrusion at L4-L5 and Grade I spondylolisthesis with bilateral spondylolisthesis at L5 on S1 with mild facet arthropathy at L5-S1 bilateral and mild bilateral foraminal stenosis at L5-S1 with disc space narrowing and 3.0mm of anterior spondylolisthesis L5 on S1 and with bilateral lower extremity lumbar radiculitis; (6) Low back strain 2003 while lifting a suitcase working as housekeeper [REDACTED] for a different employer, following which the applicant was off work for 5 months; (7) History of urinary incontinence; (8) Sleep disturbance because of low back pain; (9) sexual disturbance because of low back pain; and (10) Stress, anxiety, fearfulness, and depression. Additionally, in his "Primary Treating Physician's Orthopedic Spine Surgery Narrative Progress Report with Request for Authorization" dated 8/29/14, [REDACTED] diagnosed the claimant with: (1) Anxiety; (2) Sleep disturbance; (3) Urinary urgency; (4) Right shoulder impingement syndrome; (5) Bilateral knee pain; (6) C5-6 disc protrusion; (7) L4-S1 degenerative disc disease; (8) Right cervical radiculopathy with mild weakness; (9) Bilateral lower extremity radiculopathy; (10) L2-S1 spondylolisthesis; (11) Headaches, cervicogenic vs. closed head injury; and (12) closed head injury without loss of consciousness. The claimant has been treated with medications, TENS unit, H-wave stimulator, injections, and surgery. Lastly, in his "Neurological Initial

Consultation" dated 6/19/14, [REDACTED] diagnosed the claimant with: (1) Closed head injury with concussion; (2) Bilateral temporomandibular joint syndrome secondary to jaw lash; (3) Cervical strain; and (4) Thoracolumbar sprain.

IMR ISSUES, DECISIONS AND RATIONALES

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

Neuro psychometric testing: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Head Chapter

Decision rationale: The CA MTUS does not address the use for neuropsychological testing therefore, the Official Disability Guideline regarding the use of neuropsychological testing for head trauma will be used as a reference for this case. Based on the review of the medical records, the claimant has continued to experience chronic pain as well as headaches since her injury in October 2013. In his "Neurological Initial Consultation" dated 6/19/14, [REDACTED] indicated that a current complaint of the claimant's was "some lapses of attention." There were no other cognitive issues described. In his report, he stated, "If this woman continues to have difficulties with cognition, she would benefit from neuropsychometric testing." Despite this statement, he did not request neuropsychological testing. In fact, there is very little mention of any cognitive impairments exhibited by the claimant within the medical records that would substantiate the request for neuropsychological testing. As a result, the request for "Neuro psychometric testing" is not medically necessary.