MAXIMUS Federal Services

Case Number:	CM15-0116956		
Date Assigned:	06/25/2015	Date of Injury:	01/07/2013
Decision Date:	07/24/2015	UR Denial Date:	06/05/2015
Priority:	Standard	Application Received:	06/17/2015

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: California
Certification(s)/Specialty: Psychologist

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 40 year old male, who sustained an industrial injury on 1/7/13. He reported initial complaints of trauma resulting in fractured upper and lower jaw. The injured worker was diagnosed as having open mandibular fracture; open maxilla fracture and alveolar ridge; aftercare following surgery for injury. Treatment to date has included multiple surgical repairs. Diagnostics included CT scan facial sinuses (1/7/13). Currently, the PR-2 notes dated 5/26/15 indicated the injured worker was seen on this day as follow-up care of facial and jaw injuries. The injured worker experienced lacerations to the chin, lower lip and fractured mandible and maxilla. He has been followed by an oral surgeon with multiple surgical repairs since the injury. This has included surgical debridement of bone, mucosa, muscle and skin; open reduction anterior maxillary dentoalveolar fractures; alveolopasty of 2 quadrants of alveolar bone; extraction of 9, 10, 11, 24, 25 and 5 teeth; open reduction internal fixation left maxillary bone fracture; open reduction internal fixation of right parasymphseal mandible fracture; intraoperative placement of intermaxillary fixation/removal; complex repair lower lip laceration 5cm in length; including vermilion border; repair of chin laceration 1cm of complex nature (1/8/13) and status post open reduction internal fixation fractures and repair of lacerations (1/11/13); status post-harvest right anterior iliac crest bone grafting, debridement anterior maxilla; placement 2 corticocancellous blocks bone grafting (6/18/13); surgical debridement right premaxillary region; bone graft anterior maxilla with allograft, sponge and putty; hardware removal left anterior maxilla; uncovered dental implants #26 and 24 (4/23/14); implant placement #7, 9, 10, 12, 26 (12/3/14); removal of implant #9 and placement of bone implant #9 and 10 (4/5/15); surgical placement endosteal implant #10 (4/15/15). He was using a partial denture and eating and swallowing is improving but still has issues with the lower lip allowing

him to lead fluids due to the irregular margins from the repair. He presents today with concerns of memory issues since the injury. Physical examination notes a healed scar of the lower lip with slight irregularity of the border. No gross deformity of the jaw or maxilla appreciated. He has multiple lost teeth upper more than lower. The jaw opening and closing midline with no significant tempomandibular joint pain. His speech is fluent directed with dysarthria and muscles of the fascial expression are intact. His palate elevation and tongue protrusion is midline. He notes a normal gait. The provider is requesting authorization for a Neuropsychology evaluation.

IMR ISSUES, DECISIONS AND RATIONALES

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

Neuropsychology evaluation: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Chapter 7, page 127.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official disability guidelines, Chapter Head, topic: Neuropsychological testing. March 2015 update.

Decision rationale: 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/m TBI. 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 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. A request was made for a neuropsychological evaluation; the request was non-certified by utilization review which provided the following rationale: "In this case, the patient is being treated for a complex condition. However, there is a lack of subjective complaints and objective findings in the documentation provided for review of neuropsychological concern to support this request." This IMR will address a request to overturn the utilization review decision of non-certification. The provided medical records reflect that this patient sustained an injury when he was changing a strut on a wall press and the

strut spring exploded in his face, and broke his upper and lower jaw. This mechanism of injury suggests the possibility of neurological involvement due to the force that was applied to his face. It is noted on a physician progress report PR-2 from May 26, 2015 that "Chief concern for myself was his wife's concern that he was having some memory issues (did not report loss of consciousness)." In contrast to the utilization review statement that there is no significant symptoms being reported the finding of this IMR is that there is some concern of memory problems being verbalized by the patient's spouse and this appears to be sufficient cause for establishment of the medical necessity of this request. Therefore, because the medical necessity this request appears to be established, medically necessary and reasonable, the utilization review determination of non-certification is overturned.