

<b>Case Number:</b>	CM15-0119177		
<b>Date Assigned:</b>	06/29/2015	<b>Date of Injury:</b>	06/11/2001
<b>Decision Date:</b>	07/31/2015	<b>UR Denial Date:</b>	05/22/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/19/2015

### 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: Texas, New York, California  
 Certification(s)/Specialty: Preventive Medicine, Occupational 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 applicant is a represented 30-year-old who has filed a claim for chronic pain syndrome, posttraumatic headaches, migraine headaches, major depressive disorder (MDD) reportedly associated with an industrial injury of June 11, 2001. In a Utilization Review report dated May 22, 2015, the claims administrator failed to approve a request for a "head impulse test." The claims administrator interpreted the request as a test for Vertigo. The claims administrator referenced a May 19, 2015 RFA form and associated progress note of May 13, 2015 in its determination. The applicant's attorney subsequently appealed. The claims administrator's medical evidence log, however, suggested that most recent note on file was dated January 6, 2015. Thus, the May 13, 2015 progress note and associated May 19, 2015 RFA form made available to the claims administrator were not seemingly incorporated into the IMR packet. On October 8, 2014, the applicant reported ongoing issues with depression, chronic pain, migraines, and post-concussive syndrome. The applicant was asked to pursue transcranial magnetic stimulation, pain psychology and vestibular rehabilitation. A multidisciplinary pain program was proposed. The applicant had tried various medications over the course of the claim, with no relief. Vestibular therapy had been temporarily helpful, it is suggested. On a January 6, 2015 RFA form, cognitive therapy, biofeedback and psychiatric consultation were endorsed

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Head impulse test:** Overturned

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation The Clinical Differentiation of Cerebellar Infarction from Common Vertigo Syndromes, Nov 2009, pg 273-277.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 169. Decision based on Non-MTUS Citation [http://www.medscape.com/viewarticle/422863\\_3](http://www.medscape.com/viewarticle/422863_3) - The Ten-Minute Examination of the Dizzy Patient, Department of Otolaryngology, Division of Head and Neck Surgery, Washington University School of Medicine, Saint Louis, Missouri. Semin Neurol. 2001;21(4) Head Thrust Test (Head Impulse Test).

**Decision rationale:** The request for a head impulse test was medically necessary, medically appropriate, and indicated here. The MTUS Guidelines in ACOEM Chapter 8, page 169 on Physical Examination notes that the physical examination of individuals presenting with neck pain includes neurologic screening. Medscape further notes that a head impulse test represents a low tech, in-office means of assessing vestibular dysfunction. The test is performed in the office setting, either via direct observation of pupillary movement or via usage of an ophthalmoscope to document eye movement. Here, the applicant did present on multiple historical office visits alleging issues with dizziness, headaches, imbalance, etc., earlier attributed to depression. While it is acknowledged that the May 2015 progress note on which the article in question was proposed was not incorporated into the IMR packet, the historical information on file, in this case, does support the need for the head impulse test, a low-tech, in-office means of assessing the vestibular dysfunction. Therefore, the request was medically necessary.