

Case Number:	CM15-0126828		
Date Assigned:	07/13/2015	Date of Injury:	12/22/2011
Decision Date:	08/10/2015	UR Denial Date:	06/05/2015
Priority:	Standard	Application Received:	06/30/2015

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 51 year old female who sustained a work related injury December 22, 2011. Past history included s/p left shoulder arthroscopic decompression, Mumford and bicipital tenodesis, s/p left facial nerve decompression for hemifacial spasm June 2011, right endoscopic carpal tunnel release November 2012, and right and left open carpal tunnel release May 2013 and August 2013, type II diabetes, hypertension, and anxiety. An initial primary treating physician's evaluation, dated August 20, 2014, reveals the injured workers overall stressful work environment resulting in anxiety, stress, palpitations, headaches, and sleeping problems. She underwent numerous procedures including; intravenous lidocaine, epidural and facet injections, rhizotomy, and occipital nerve blocks. According to a qualified medical re-evaluation, dated May 7, 2015, the injured worker presented with a return of her hemifacial spasm and severe headaches. Neurological examination revealed; normal gait, she can see and move her eyes both sides, facial sensation and symmetry appear normal, and hearing is intact. Motor examination revealed good strength, finger to nose testing produced a violently exaggerated tremor on the right, some on the left. Sensory and cerebellar exam are intact. Reflexes are trace with down going toes. Impression is documented as post-operative hemifacial spasm; degenerative disease of the cervical spine; headaches. The physician documented previously ordering neuropsychological testing which had not been authorized or implemented. At issue, is a request for authorization for neuropsychological testing.

IMR ISSUES, DECISIONS AND RATIONALES

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

Neuropsychological Testing: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Psychological evaluations Page(s): 100-101.

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

Decision rationale: Citation Summary 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/mTBI. 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 neuropsychological testing, the request was not certified by utilization review with the following provided rationale: "neuropsychological testing is requested for diagnosis of anxiety which is thought to be the cause of hemifacial spasm. There is no documentation of any cognitive deficits. Neuropsychological testing is indicated for evaluation of cognitive deficits. The psychological evaluation is appropriate for evaluation of anxiety." This IMR will address a request for overturning the utilization review decision. The medical appropriateness of this request is not established by the provided documentation. The patient is noted according to a December 17, 2014 evaluation to have an entrenched chronic pain syndrome with somatoform disorder. It was also noted that primary treating physician recommended home cranial electrotherapy stimulation unit for the treatment of her residual headaches, occipital neuralgia, and mood and sleep disorder but this was denied." The mechanism of injury is noted do to repetitive work. It does not appear that she suffered from a brain injury. It is noted that she was working "100 hours a week with only 10 hours of sleep and

that the patient felt that this may have contributed to her symptoms." According to a physician progress note from May 7, 2015 the patient was evaluated at [REDACTED] by a neurosurgeon who stated that the issue was anxiety induced. She also saw a neurologist at [REDACTED] and was told she needed the surgery for neuroma, however this was later contradicted by another physician said that she did not have an aroma but that she needs some neck surgery. The request for neuropsychological testing is related to reports of symptoms of anxiety and hemifacial spasm. A neuropsychological examination is a comprehensive examination designed to assess cognitive deficits typically as a result of head injury or other neurological trauma/illness. In this case there is no report of cognitive deficits, head injury or neurological illness. Symptoms of headache, anxiety and severe facial spasm would not be addressed by a neuropsychological exam and would be better directed to a more appropriate form of evaluation that would better address the patient's symptomology. For this reason the medical necessity of the request is not established in the utilization review decision is upheld.