Case Number:	CM16-0236906		
Date Assigned:	12/13/2016	**Date of Injury:**	10/27/2016
Decision Date:	01/10/2017	**UR Denial Date:**	11/22/2016
Priority:	Standard	**Application Received:**	12/09/2016

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: Internal 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 injured worker is a 32 year old male, who sustained an industrial injury on 10-27-2016. The injured worker was being treated for postconcussion syndrome, skull vault fracture-initial, and migraine. Treatment to date has included diagnostics, observation, and medications. On 11-15-2016 (Neurology), the injured worker was seen for evaluation of an episode of loss of consciousness. The injured worker reported that while playing basketball on 10-27-2016, he had sudden onset of loss of consciousness and fell to the ground, hitting the right side of his head. The injured worker reported that an eye witness told him that his eye was open at the time, and there was no report of stiffening or convulsing at that time. Computerized tomography of the brain was documented as showing a right frontal skull fracture, with no intracranial bleeding or hematoma seen. The injured worker reported headaches with nausea and vomiting while kept in the hospital overnight, and was sent home the following day. The injured worker reported having a headache for the next few days "and then he was better". The injured worker denied alcohol or tobacco use. The injured worker currently denied headache, dizziness, or vertigo. Past medical history included migraine headaches since 13 years old (approximately every 6 months) and febrile seizures x2 at 2 years old. Physical exam noted blood pressure 116 over 78 and pulse 61. The injured worker was alert and oriented, with good memory to recent and remote events, normal speech, normal visual fields, good hearing, no motor weakness, intact sensation, and no incoordination or ataxia. The provider recommended an electroencephalogram, to rule out seizure, with further management and treatment after the electroencephalogram, and follow-up in

3-4 months. A Request for Authorization dated 11-16-2016 was noted for electroencephalogram. On 11-22-2016 Utilization Review non-certified a request for 1 electroencephalogram.

IMR ISSUES, DECISIONS AND RATIONALES

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

Electroencephalogram: Upheld

Claims Administrator guideline: The Claims Administrator based their decision on recommendation(s) outside of the MTUS Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines, Head Chapter (updated 11/3/16): EEG (neurofeedback).

MAXIMUS guideline: The Expert Reviewer based their decision on recommendation(s) outside of the MTUS Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Head section, Electroencephalography.

Decision rationale: Pursuant to the Official Disability Guidelines, electroencephalogram is not medically necessary. Recommended as indicated below. EEG (electroencephalography) is a well-established diagnostic procedure that monitors brain wave activity using scalp electrodes and provocative maneuvers such as hyperventilation and photic strobe. Information generated includes alterations in brain wave activity such as frequency changes (nonspecific) or morphologic (seizures). EEG is not generally indicated in the immediate period of emergency response, evaluation, and treatment. Following initial assessment and stabilization, the individual's course should be monitored. See also QEEG (brain mapping) and Video EEG. Indications for EEG: If there is failure to improve or additional deterioration following initial assessment and stabilization, EEG may aid in diagnostic evaluation. (Colorado, 2005) (Vespa, 2005) (Thompson, 2005) (Thornton, 2005) (Hudak, 2004) (Nuwer, 1997). In this case, the injured worker's working diagnoses are post concussion syndrome; and skull fracture. Date of injury is October 27, 2016. Request for authorization is November 16, 2016. The injured worker is a 32-year-old that struck his head with loss of consciousness times one minute. It was a frontal hematoma. A CAT scan dated October 27, 2016 shorting nondisplaced skull fracture. A repeat CAT scan was performed the following day. There were no new changes. According to a November 15, 2016 neurology new patient evaluation, the injured worker was being seen for evaluation for loss of consciousness (on date of injury). There was no witnessed seizure activity. Headaches lasted a few days. Injured worker has history of migraine headaches. Objectively, the injured worker was awake, alert with good recent and long-term memory. Speech was normal. Neurologic evaluation was otherwise normal. The treating provider is requesting an EEG. EEG is not generally indicated in the immediate period of emergency response, evaluation, and treatment. If there is failure to improve or additional deterioration following initial assessment and stabilization, EEG may aid in diagnostic evaluation. The documentation shows the injured worker was followed up two weeks after the date of injury. There was no documentation of witnessed seizure activity. There was no failure to improve and there was no additional deterioration after the initial assessment and stabilization. The injured worker's neurologic physical examination was normal. Consequently, an EEG is not clinically indicated. Based on clinical information in the medical record and peer review evidence-based guidelines, electroencephalogram is not medically necessary.