

Case Number:	CM14-0003625		
Date Assigned:	01/31/2014	Date of Injury:	07/25/2013
Decision Date:	06/30/2014	UR Denial Date:	12/10/2013
Priority:	Standard	Application Received:	01/09/2014

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 Occupational Medicine, 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 patient is a 62-year-old male who has submitted a claim for Posttraumatic Headaches, Tinnitus, and Low Back Pain with L5-S1 Disc Disease, associated with an industrial injury date of July 25, 2013. Medical records from 2013 were reviewed, which showed that the patient complained of headaches and back pain. On physical examination, the patient was alert, oriented, and answered questions appropriately. There was tenderness of the posterior occipital region. Range of motion of the neck was full. Examination of the eyes and ears were unremarkable. There was tenderness of the lumbar region. Range of motion of the lumbar spine was poor. Straight leg raise test was negative. CT of the head/brain, dated August 23, 2013, revealed unremarkable findings. Treatment to date has included medications, physical therapy, and home exercise program. Utilization review from December 10, 2013 denied the request for initial MRI brain because the clinical documentation did not include a CT and there was no evidence that the patient underwent a prolonged interval of disturbed consciousness or has previous trauma or disease that complicated the patient's injury.  

IMR ISSUES, DECISIONS AND RATIONALES

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

INITIAL MRI BRAIN: 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 Official Disability Guidelines (ODG) Head, MRI (Magnetic Resonance Imaging)

Decision rationale: CA MTUS does not specifically address MRI of the brain. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, the Official Disability Guidelines (ODG) was used instead. ODG states that a brain MRI is recommended for the following indications: (1) to determine neurological deficits not explained by CT; (2) to evaluate prolonged interval of disturbed consciousness; and (3) to define evidence of acute changes superimposed on previous trauma or disease. The 8/8/13 medical report documented that the patient fell and hit the back of his head but denied any loss of consciousness. He did complain of squeezing-type headache over the back of his head and dizziness with movement, but no vertigo. An 8/23/13 CT brain scan was reported as unremarkable. However, the medical records failed to provide evidence of impairment in consciousness or exacerbation of symptoms. The 9/9/13 medical report included progressive symptoms of ringing in the ears. The 12/2/14 medical report described constant occipital headaches radiating to the front of the head worse with activity. In addition, the patient continued to have symptoms consistent with tinnitus. He was authorized to see a neurologist. A limited mental status exam was normal and the patient was described as "neurologically intact". Diagnoses included chronic headaches status-post concussion. A brain MRI was requested despite the fact that a neurology consult was imminent. There is no clear indication for a brain MRI at this time especially since the patient is neurologically-intact both physically and mentally when considering a possible brain injury, and considering an imminent neurology consult. Therefore, the request for INITIAL MRI BRAIN is not medically necessary.