

Case Number:	CM14-0015321		
Date Assigned:	04/09/2014	Date of Injury:	05/05/2006
Decision Date:	08/19/2014	UR Denial Date:	01/13/2014
Priority:	Standard	Application Received:	02/06/2014

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 Physical Medicine and Rehabilitation, has a subspecialty in Sports Medicine and is licensed to practice in Texas and New York. 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 injured worker is a 43-year-old female with a reported date of injury on 05/05/2006. The mechanism of injury was not provided within the documentation. The worker was injured again on 10/23/2013 when a wooden door crushed her left hand. The clinical note dated 02/19/2014 noted the injured worker reported pain to her neck, bilateral shoulders, bilateral elbows, wrist, hand, back, and right knee. The injured worker has had previous treatments including chiropractic therapy, which did provide temporary relief and physical therapy. The injured worker has had several x-rays of multiple body parts that showed no fractures. The injured worker's medication regimen included Norco, Soma, Protonix, Dyazide, Seroquel, Lexapro, Ambien, Ativan, tramadone, Bentyl, Zophra, Lomotil, and Florcet. The injured worker complained frequent headaches. She had numbness and tingling to her shoulders, elbows, hands, wrists and fingers and increased pain when gripping and grasping with both hands. Her lower back pain radiated down into her hips, her buttocks, and the back of her thighs. She reported intermittent right knee pain, which occasionally made her walk with an uneven gait. The injured worker did show normal strength to the bilateral upper extremities and lower extremities. There was no tenderness noted to the cervical spine. Her diagnoses included bilateral carpal tunnel syndrome, bilateral de Quervain's, bursitis right shoulder, medial and lateral epicondylitis of the left elbow, left ulnar neuropathy, bilateral patellofemoral chondromalacia, cervical spine and lumbar spine. The recommended plan of treatment was for ongoing prophylactic restrictions. There was no mention of an MRI of the brain in this report. There was an examination on 09/30/2013 for a follow-up visit where the injured worker complained of neck pain radiating to both upper extremities and having cervicogenic headaches. The recommended plan of treatment

at that time was MRI of the brain neurology consult. The request for authorization was not provided, nor was the rationale.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI OF THE BRAIN: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES, HEAD.

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.

Decision rationale: The request for an MRI of the brain is not medically necessary. The injured worker had complaints of neck pain, bilateral shoulder pain, bilateral elbow, wrist and hand pain and headaches. The Official Disability Guidelines recommend an MRI of the brain to determine neurological deficits not explained by a CT scan, to evaluate prolonged interval of disturbed consciousness, and to define evidence of acute changes superimposed on previous trauma or disease. There is no evidence that a CT scan was performed, and there is no evidence of disturbed consciousness. There is no indication of acute changes, previous trauma or disease that within the provided documentation. Furthermore, there is no evidence to support the need for an MRI of the brain. The physician's rationale for the request was not provided within the medical records. Therefore, the request for the MRI of the brain is not medically necessary.