

Case Number:	CM14-0198676		
Date Assigned:	12/09/2014	Date of Injury:	05/08/2012
Decision Date:	01/23/2015	UR Denial Date:	11/21/2014
Priority:	Standard	Application Received:	11/26/2014

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 Internal 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 an injured worker with a history of head injury. The agreed medical examiner report dated September 5, 2014 documented that the patient was involved in an accident on May 8, 2012. He was struck by a piece of metal over the vertex of the skull. He was wearing a helmet when the event occurred. He reports no loss of consciousness in that event. He reports the immediate onset of headache and cervical pain. He had headache and a contusion over the skull. He had headache, cervical pain and impaired memory. Skull x-rays dated 5/8/12 were normal. He indicates a course of physical therapy was provided for the cervical symptomatology. He has self-treated with Motrin at a frequency of three times per day. The patient reports headache. The headache is not associated with nausea or vomiting. He reports intermittent blurred vision of both eyes with the headache but no fixed visual loss. He does not wear glasses. He reports no history of seizure. He reports difficulty with memory. The memory impairment is more prominent than that initially noted. The patient has persistent cervical pain. He indicates the pain is bilateral with radiation to the hands bilaterally. He reports weakness of both hands sufficient to drop objects. He reports intermittent sensory disturbance over both hands but no fixed sensory loss. Physical examination was documented. The patient was cooperative and alert. There is no evidence of dysarthria or aphasia. Cranial nerves II through XII are intact. Gait and tandem walk are normal. The patient was able to walk on heels and toes. No drift is present of the outstretched arms. There is no atrophy or fasciculation. Motor, tone and strength are normal throughout. A normal response to position, two-point discrimination, pin, vibration and traced figures is present throughout. Range of motion of the cervical spine is restricted because of pain. Tenderness without spasm is present in the cervical paravertebral muscles bilaterally. Diagnoses included a history of headache, cervical pain, head injury, laceration of scalp, and scalp contusion. The primary treating physician's progress report dated October 1, 2014 documented subjective

complaints of head and neck pain. The patient was being seen for headaches associated with chronic pain. The patient complains of back pain and tired. He reports taking Advil as needed. Physical examination was deferred. The physical exam was not performed. Diagnoses were post-concussion syndrome, headaches, myofascial pain syndrome, cervicgia, chronic pain syndrome, and insomnia. MRI magnetic resonance imaging of the brain without contrast was requested. Utilization review determination date was November 21, 2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI of the brain without contrast: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines

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: Medical Treatment Utilization Schedule (MTUS) does not address MRI magnetic resonance imaging of the brain. Official Disability Guidelines (ODG) state that indications for MRI magnetic resonance imaging are to determine neurological deficits not explained by CT computed tomography, to evaluate prolonged interval of disturbed consciousness, and to define evidence of acute changes super-imposed on previous trauma or disease. Neuroimaging is not recommended in patients who sustained a concussion mild traumatic brain injury beyond the emergency phase (72 hours post-injury) except if the condition deteriorates or red flags are noted. Medical records document a head injury on May 8, 2012. The patient was wearing a helmet when the event occurred. He reported no loss of consciousness. Skull x-rays dated 5/8/12 were normal. The primary treating physician's progress report dated October 1, 2014 noted that physical examination was deferred. The physical exam was not performed. The 10/1/14 progress report was the latest report present in the submitted medical records. MRI magnetic resonance imaging of the brain without contrast was requested on 11/14/14. Without a recent physical examination documented, the 10/1/14 progress report do not provide support for the performance of MRI magnetic resonance imaging of the brain. Therefore, the request for MRI of the brain without contrast is not medically necessary.