

Case Number:	CM13-0018981		
Date Assigned:	10/11/2013	Date of Injury:	06/24/2010
Decision Date:	02/03/2014	UR Denial Date:	08/19/2013
Priority:	Standard	Application Received:	09/03/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Physical Medicine and Rehabilitation, 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 physician 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 38-year-old female with a reported date of injury on 06/24/2010. The patient presented with left upper extremity pain and tenderness over the right deltoid. The patient had a diagnosis of pain in the joint, forearm. The physician's treatment plan included a request for 6 sessions of aftercare: [REDACTED].

IMR ISSUES, DECISIONS AND RATIONALES

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

Six (6) sessions of aftercare: [REDACTED]: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Conditions of greater than three months duration - Chronic Pain Ma.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (chronic), Office visits

Decision rationale: The Official Disability Guidelines note the need for a clinical office visit with a health care provider is individualized based upon a review of the patient concerns, signs and symptoms, clinical stability, and reasonable physician judgment. The determination is also based on what medications the patient is taking, since some medicines such as opiates, or medicines such as certain antibiotics, require close monitoring. As patient conditions are

extremely varied, a set number of office visits per condition cannot be reasonably established. The determination of necessity for an office visit requires individualized case review and assessment, being ever mindful that the best patient outcomes are achieved with eventual patient independence from the health care system through self-care as soon as clinically feasible. Within the provided documentation it did not appear the patient was utilizing medications that would require close monitoring. The requesting physician did not include a complete and adequate assessment of the patient's current objective functional condition in order to demonstrate conditions needing monitoring and follow-up. Additionally, the request did not include dates of the appointments being requested. Therefore, the request for 6 sessions of aftercare: [REDACTED] is neither medically necessary nor appropriate.