

<b>Case Number:</b>	CM13-0030109		
<b>Date Assigned:</b>	06/23/2014	<b>Date of Injury:</b>	09/04/2012
<b>Decision Date:</b>	08/11/2014	<b>UR Denial Date:</b>	08/29/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/25/2013

### 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 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 injured worker is a 53-year-old male who reported an injury on 09/04/2012. The mechanism of injury was not provided for clinical review. The diagnoses included sprain of the unspecified site of the knee and leg. Previous treatments include medication. Within the clinical note dated 07/23/2013, it was reported the injured worker complained of left knee pain. On physical examination of the left knee, the provider noted a tender medial joint line. The provider requested a transfer of care to [REDACTED] or [REDACTED]. However, rationale was not provided for clinical review. The request for authorization was submitted and dated 07/31/2013.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Transfer of care to [REDACTED] or [REDACTED]:** 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:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 341. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Knee, Office Visits.

**Decision rationale:** The California MTUS/ACOEM Guidelines state physician followup can occur when a release to modified, increased, or full duty is increased or after appreciable healing

or recovery can be expected, on average. In addition, the Official Disability Guidelines recommend office visits as determined to be medically necessary. Evaluation and management of outpatient visits to the office of a medical doctor plays a crucial role in the proper diagnosis and return to function of an injured worker, and they should be encouraged. The need for a clinical office visit with a healthcare provider is individualized based on the review of the patient's concerns, signs and symptoms, clinical stability, and reasonable physician judgment. The determination is also based on the medication the patient is taking, since some medicines such as opioids, or other 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. Therefore, Transfer of care to [REDACTED] or [REDACTED] is not medically necessary.