

Case Number:	CM13-0049532		
Date Assigned:	02/03/2014	Date of Injury:	07/23/2010
Decision Date:	04/30/2014	UR Denial Date:	09/25/2013
Priority:	Standard	Application Received:	10/18/2013

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 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 a 51-year-old male who reported an injury on 07/23/2010 per the Application of Independent Medical Review; however, per the physician documentation, the patient reported injury on 08/13/2012 with the mechanism of injury being the patient and a customer were carrying a large box containing fur and the patient was in the lower end walking backwards when he suddenly slipped and fell down 3 stairs. The patient had labs on 06/26/2013 which were within normal limits. The documentation per the internal medicine physician visit on 06/25/2013 revealed the patient reported episodes of shortness of breath when he had stress; however, the diagnostic testing did not indicate the patient had ischemia and the patient's symptoms were most consistent with anxiety. The physician opined there does not appear to be any underlying organic internal medicine caused for his anxiety. He was advised to continue with treatment for his hypertension and associated symptoms with his prescribing physician. The documentation of 09/05/2013 revealed the patient should followup with internal medicine with laboratory services. The patient's diagnosis was low back pain. The rest of the note was difficult to read. The request was made for an internal medicine consultation.

IMR ISSUES, DECISIONS AND RATIONALES

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

INTERNAL MEDICINE FOLLOW-UP: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine, Chapter 7- Independent Medical Examinations and Consultations

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG) LOW BACK OFFICE VISIT

Decision rationale: Official Disability Guidelines indicate the need for a clinical office visit with a healthcare provider is individualized based upon a review of the patient's concerns, signs, and symptoms, clinical stability, and reasonable physician judgment. The clinical documentation submitted for review indicated the patient's prior laboratory studies were within normal limits. There was a lack of documentation including the patient's blood pressure as it was made mention in the previous documentation that the patient had a history of hypertension. There was lack of documented rationale for the patient to return to the internal medicine physician. The request as submitted also failed to indicate the quantity of internal medicine followups that were being requested. Given the above, the request internal medicine followup is not medically necessary.