

<b>Case Number:</b>	CM13-0059215		
<b>Date Assigned:</b>	12/30/2013	<b>Date of Injury:</b>	02/20/2007
<b>Decision Date:</b>	05/06/2014	<b>UR Denial Date:</b>	10/29/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/27/2013

### 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 62-year-old male who reported injury on 02/20/2007. The mechanism of injury was the injured worker stepped on a piece of rebar and twisted his right leg and knee. The injured worker underwent a knee replacement on 11/03/2009. The documentation of 10/14/2013 revealed the injured worker had a sensory examination that was decreased in both legs. There was no significant weakness with the legs but the examination was difficult due to knee and hip problems. The diagnoses included left hip severe osteoarthritis, left knee severe osteoarthritis, and right knee osteoarthritis status post total knee replacement. The submitted request was for office visit follow-ups.

### IMR ISSUES, DECISIONS AND RATIONALES

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

#### **6 OFFICE VISITS WITH A HEALTHCARE PROVIDER: Upheld**

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG), KNEE & LEG CHAPTER, OFFICE VISITS

**Decision rationale:** Official Disability Guidelines recommend office visits with a healthcare provider based upon the review of the patient's concerns, signs and symptoms, clinical stability, and reasonable physician judgment. Additionally, as patient conditions are extremely varied, a set number of visits per condition cannot be reasonably established. There is neither DWC Form RFA nor request for the service. The clinical documentation submitted for review failed to indicate the necessity for 6 office visits. This request would be excessive. Given the above, the request for 6 office visits with a healthcare provider is not medically necessary.