

Case Number:	CM13-0070191		
Date Assigned:	01/03/2014	Date of Injury:	01/07/2012
Decision Date:	06/04/2014	UR Denial Date:	12/09/2013
Priority:	Standard	Application Received:	12/24/2013

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 Preventive 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:

According to the records made available for review, this is a 47-year-old with a date of injury of January 7, 2012. At the time of the Decision for ongoing care with [REDACTED] and ongoing care with [REDACTED] (December 9, 2013), there is documentation of subjective (neck pain with upper extremity symptoms and low back pain with bilateral lower extremity symptoms) and objective (tenderness to palpation over the AC joint and the biceps, and positive impingement sign) findings, current diagnoses (degenerative disc disease of the cervical, thoracic, and lumbar spine; cervical retrolisthesis; and herniated discs and canal stenosis of cervical spine), and treatment to date (physical therapy, acupuncture, chiropractic treatment, epidural injections, and medications). Medical reports identify a request for ongoing follow up visits with [REDACTED], who has previously evaluated the patient for rib/sterna injuries, and that [REDACTED] documented, in the most recent visit, that the patient's costochondritis and sterna pain had resolved, and that patient should follow up as needed for worsening symptoms. In addition, medical reports identify that there is a previous certification for the patient to follow up with [REDACTED], which has not taken place yet.

IMR ISSUES, DECISIONS AND RATIONALES

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

ONGOING CARE WITH [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, Neck and Upper Back (Acute and Chronic).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Independent Medical Examinations and Consultations Chapter (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 7), page 127, as well as the Official Disability Guidelines (ODG) Pain Chapter, Office Visits.

Decision rationale: The Independent Medical Examinations and Consultations Chapter of the ACOEM Practice Guidelines state that the occupational health practitioner may refer to other specialist if a diagnosis is uncertain or extremely complex, when psychosocial facts are present, or when the plan or course of care may benefit from additional expertise. The ODG identifies that office visits are based upon a review of the patient concerns, signs and symptoms, clinical stability, and reasonable physician judgment. Within the medical information available for review, there is documentation of diagnoses of degenerative disc disease of the cervical, thoracic, and lumbar spine; cervical retrolisthesis; and herniated discs and canal stenosis of cervical spine. In addition, there is documentation of a request for ongoing follow up visits with [REDACTED], who has previously evaluated the patient for rib/sterna injuries. Furthermore, there is documentation that [REDACTED] documented, in the most recent visit, that the patient's costochondritis and sterna pain had resolved, and that patient should follow up as needed for worsening symptoms. However, there is no documentation of worsening symptoms and a rationale identifying the medical necessity of the requested ongoing care with [REDACTED]. In addition, given documentation of the request for ongoing care with [REDACTED], there is no (clear) documentation of the number of visits requested. The request for ongoing care with [REDACTED] is not medically necessary or appropriate.

ONGOING CARE WITH [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, Neck and Upper Back (Acute and Chronic).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Independent Medical Examinations and Consultations Chapter (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 7), page 127, as well as the Official Disability Guidelines (ODG) Pain Chapter, Office Visits.

Decision rationale: The Independent Medical Examinations and Consultations Chapter of the ACOEM Practice Guidelines state that the occupational health practitioner may refer to other specialist if a diagnosis is uncertain or extremely complex, when psychosocial facts are present, or when the plan or course of care may benefit from additional expertise. The ODG identifies that office visits are based upon a review of the patient concerns, signs and symptoms, clinical stability, and reasonable physician judgment. Within the medical information available for review, there is documentation of diagnoses of degenerative disc disease of the cervical, thoracic, and lumbar spine; cervical retrolisthesis; and herniated discs and canal stenosis of cervical spine.

In addition, given documentation of certification for previous request for a follow up visit with [REDACTED], which has not taken place yet, there is no documentation of rationale identifying the medical necessity of the current requested ongoing care with [REDACTED]. In addition, given documentation of the request for ongoing care with [REDACTED], there is no (clear) documentation of the number of visits requested. The request for ongoing care with [REDACTED] is not medically necessary or appropriate.