

Case Number:	CM13-0071631		
Date Assigned:	05/14/2014	Date of Injury:	12/20/2005
Decision Date:	08/22/2014	UR Denial Date:	12/05/2013
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 Occupational 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:

This is a 57-year-old male patient with a 12/20/2005 date of injury. The patient tripped and fell on steps, landing on his left knee resulting in injury to his left knee and ankle. 12/20/2011 x-ray showed moderate degenerative disc disease at L1-2. 12/20/2012. EMG showed impairment, suprasegmental activation of motor units in the left leg; possible mild distal sensory neuropathy with absent plantar sensory responses. 04/19/2013 progress report indicated that the patient complained about lower back and left knee pain rated 8/10. The patient uses a walker. Physical exam did not assess the range of motion of the lumbar spine due to severity of pain. The patient was unable to heel or toe walk. The most recent available progress report dated on 11/18/13 indicated that the patient's complaints changed. He had constant lower back pain, associated with shooting pain down to the left leg. He continued to complain of left leg pain. The patient started having ankle pain and swelling. He was diagnosed with chronic low back pain, left knee pain, status post arthroscopy. Treatment included Norco 10/325 6/d, Voltaren 100 1 p.o., Neurontin 300 mg t.i.d, Prilosec 20mg 1 p.o. Treatment to date: activity modification, walker, medication management. There is documentation of a previous 12/05/2013 adverse determination, based on the fact that 10/21/2013 report did not relate any current GI symptoms or elevated risk for a GI event. Office visit request was modified from 12 visits to 3 visits, based on the fact that there was no rationale to support medical necessity of 12 office visits.

IMR ISSUES, DECISIONS AND RATIONALES

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

Office Visit X 12: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG TWC (Official Disability Guidelines Treatment of Workers Compensation) Pain: Office visits.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter Office Visits Other Medical Treatment Guideline or Medical Evidence: FDA (Prilosec).

Decision rationale: CA MTUS does not address this issue. ODG states that evaluation and management (E&M) outpatient visits to the offices of medical doctor(s) play a critical role in the proper diagnosis and return to function of an injured worker, to monitor the patient's progress, and make any necessary modifications to the treatment plan. 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. However, the patient's most recent available progress report dated on 11/18/13 indicated that the patient still had severe pain in his lower back associated with the shooting pain to the left leg. The guidelines do support ongoing management and evaluation by the patient's primary treating provider. In the previous UR decision dated on 12/5/13 the request for 12 office visits was modified to 3 office visits. The request for 12 office visits is excessive and not supported by guidelines. Therefore, the request for decision for office visits x 12 was not medically necessary.