

Case Number:	CM14-0018728		
Date Assigned:	04/18/2014	Date of Injury:	12/10/2012
Decision Date:	07/02/2014	UR Denial Date:	02/04/2014
Priority:	Standard	Application Received:	02/13/2014

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 23-year-old male who was injured on 12/10/2012 while working for his employer, renovating ships. The patient fell through the deck of a ship, suffering a severe injury to his head, left upper extremity, and his left ankle area. The prior treatment history has indicated that the patient continues taking Norco, Percocet and Soma. The patient underwent reconstruction of the left ankle, lateral ligamentous injury, arthrotomy and injection platelet-rich plasma (PRP) on 10/10/2013. An orthopedic consultation note dated 04/29/2013 documented that the patient was treated with rest, medications and a course of physical therapy as well as an MRI of the left ankle. His left ankle pops and feels unstable. His left wrist and thumb hurt. They are swollen with limited motion. The objective findings on exam include: Range of motion of the left wrist reveals flexion and extension 50 degrees, radial deviation 10 degrees and ulnar deviation 30 degrees. Range of motion of the left ankle reveals dorsiflexion 5 degrees, plantar flexion 40 degrees, inversion 25 degrees, eversion 10 degrees. There is 4+ drawer sign, 4+ talar shift. There is 4+ pain with range of motion and 4+ lateral ankle pain. The plan includes: The patient requires an MRI scan of his left thumb carpometacarpal (CMC) joint for further evaluation of his fracture. He would benefit from reconstructive procedure to his left ankle. The progress note dated 12/04/2013 reveals that the patient is wearing a boot over the left ankle and foot area. Deep tendon reflexes are 1+ and symmetrical at the knees. The Romberg is negative. The diagnosis includes: Multiple orthopedic injuries secondary to fall at work.

IMR ISSUES, DECISIONS AND RATIONALES

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

DERMATOLOGY CONSULTATION: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation AMERICAN COLLEGE OF OCCUPATIONAL AND ENVIRONMENTAL MEDICINE (ACOEM), 2nd EDITION, (2004), CHAPTER 7, INDEPENDENT MEDICAL EXAMINATIONS AND CONSULTATIONS, PAGE 503; AND THE OFFICIAL DISABILITY GUIDELINES (ODG), INFECTIOUS DISEASES, OFFICE VISITS.

Decision rationale: The ACOEM Guidelines indicate that a consultation is recommended to aid in the diagnosis, prognosis, therapeutic management, determination of medical stability, and permanent residual loss and/or the examinee's fitness for return to work. The Official Disability Guidelines indicate the need for a clinical office visit with a health care provider is individualized based upon a review of the patient concerns, signs and symptoms, clinical stability, and reasonable physician judgment. The guidelines recommend that consults for office visits with specialists is generally at the discretion of the provider. However, the medical records provided are mostly handwritten and largely illegible. There was insufficient documentation of a physical exam, history of skin disorders, or discussion of why dermatology consult is indicated. Based on the guidelines and as well as the lack of clinical documentation as stated above, the request is not medically necessary.