

Case Number:	CM14-0042074		
Date Assigned:	06/30/2014	Date of Injury:	09/08/2010
Decision Date:	09/15/2014	UR Denial Date:	03/26/2014
Priority:	Standard	Application Received:	04/09/2014

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 Family 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 year 61-year old female patient reported pain in her neck, mid back low back and bilateral shoulder, arms, wrists, and lower extremities on 9/8/10 which she attributed to repetitive work involved in the care of two patients for the previous 7 years. Current diagnoses include lumbar sprain, lumbosacral neuritis, brachial neuritis, neck sprain, shoulder and arm sprain, rotator cuff syndrome, tenosynovitis of hand and wrist and carpal tunnel syndrome. Current medications include benzapril, fluoxetine, gabapentin, glipizide, hydrochlorothiazide, hydroxyzine and omeprazole. A 2/4/14 progress note from her primary treater documents that the patient complained of neck and back pain with numbness and tingling in both hands. She also had low back pain radiating to both lower extremities. Review of systems is positive for fatigue, joint pain, muscle spasms, depression, anxiety, headaches and dizziness. Documented exam findings include tenderness and decreased range of motion of the back, with a positive straight leg raise eliciting "radicular symptoms of the bilateral feet", and decrease sensation of the L5 dermatome. It lists "pending internal medicine and rheumatologic consultations" under the treatment plan. There are also primary treater's progress notes dated 11/26/14 and 10/16/13 which list an internal medicine consultation as "pending". The doctor's first report is dated 9/4/13 and is signed by the primary treater. Diagnoses included neck, upper, mid and low back pain, bilateral shoulder pain, bilateral forearm, wrist and hand pain, emotional complaints with stress and sleep disturbance, history of chest pain with associated breathing difficulties, gastrointestinal upset, and "development of diabetes and aggravated high blood pressure". Musculoskeletal and neurological exams are documented. There is no exam documented of the patient's blood pressure, of any exam of her eyes, ears, mouth or throat, or of any chest, lung or abdominal exam. Authorization of internal medicine consultation is requested "to address AOE-COE-treatment needs of the patient's complaint of gastrointestinal upset in relationship to medication

usage, as well as development of diabetes and aggravated high blood pressure secondary to her chronic pain and limitations/impairment". A request for authorization for a pain consultation and for an internal medicine consultation was received in UR on 3/13/14. The pain consultation was certified and the internal medicine consultation was not certified on 3/26/14. An IMR was requested on 4/9/14 for non-certification of the internal medicine consultation.

IMR ISSUES, DECISIONS AND RATIONALES

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

Outpatient Internal Medicine: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management, Chapter 3 Initial Approaches to Treatment Page(s): 43-44, 79-80.

Decision rationale: The ACOEM Guidelines cited above state that determining whether a patient suffers from a pathologic condition may not always be straightforward. Workers may believe that they have a physical injury when the real problem is a lack of fit with their job duties. Such workers often may have multiple symptoms with non-specific physical findings. Performing multiple procedures and tests in this setting is described as an incomplete or inaccurate approach to patient assessment that may set the stage for the prolongation of medical care, delayed recovery and the development of a range of behaviors by the patient in order to prove that there is a real injury that precludes return to work. In cases of delayed recovery and prolonged time away from work, the clinician should determine whether specific obstacles are preventing the patient from returning to work. The clinician should judiciously select and refer to specialists who will support functional recovery as well as provide expert recommendations. The clinician should always think about differential diagnoses. This should involve stepping back and reevaluating the patient and the entire clinical picture. Symptoms or physical findings that have developed since the injury may not be consistent with the original diagnosis. A detailed history and physical exam should be conducted. Appropriate studies may be performed. There is no documentation of the careful assessment described above prior to referral as described above. Given the reasons documented for the referral, at the very least a blood pressure should have been checked and urine tested for glucose. There was no documented abdominal exam or check for blood in the patient's stool. No rudimentary psychological examination was documented. No differential diagnoses were entertained, including the possibility that many of the patient's complaints might be psychiatric or due her need to prove that she cannot return to work. The much more probable diagnoses of essential hypertension and of weight- and diet-related diabetes were not considered (as opposed to diabetes and "aggravated high blood pressure from pain and limitations/impairment, which are not medically-recognized diagnoses). No attempt was made to refer to specialists who would promote functional recovery. This kind of referral, made for the reasons described, is quite likely to reinforce the patient's impression that that she has multiple real work-related injuries and that she can never work again, and is also likely to stall any progress she might make toward recovery. Based on the evidence-based references cited above, and the clinical notes in this case, a referral for an outpatient internal

medicine consultation is not medically necessary due to lack of documentation of appropriate assessment of the patient prior to the referral and likelihood that such a referral will actually delay her recovery.