

<b>Case Number:</b>	CM14-0070404		
<b>Date Assigned:</b>	07/14/2014	<b>Date of Injury:</b>	12/01/2010
<b>Decision Date:</b>	08/25/2014	<b>UR Denial Date:</b>	04/11/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/15/2014

### 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 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 51-year-old female who reported an injury on 04/4/2003 due to an unknown mechanism. The injured worker was diagnosed with tenosynovitis of the hand, joint effusion, carpal tunnel syndrome, and generalized muscle weakness. Conservative care was initiated to address these issues. On 10/23/2013 the injured worker reported complaints of severe pain at 7/10 to her lower back and wrists bilaterally. She also states conservative care has not offered pain relief to the wrists, bilaterally, and the physician noted limited range of motion. She described her low back pain traveling to the lower extremities with left greater than right and difficulty falling asleep and staying asleep associated with pain. Activities of daily living are restricted due to pain. The physician notes a lumbar ESI on 9/16/2013 where the injured worker received 20% reduction in pain from a constant 8/10 to frequent 6/10 with no low back function improvement. On 10/24/2013 the injured worker rated an aching, sharp and sore pain as 7/10 to her lower back radiating to bilateral lower extremities. The injured worker continues with interrupted sleep associated with pain and a weight gain of 32 pounds since the injury. The physician notes an improvement of pain, an improvement of sleeping two to now four hours a night, ambulates with a left-sided antalgic gait, and associates this with continued conservative care and medications. The clinical note dated 12/18/2013 noted the injured worker complained of right radicular symptoms. The physician notes asymmetry, spasm with palpation to the lumbar paraspinal area, limited range of motion with flexion, and a positive straight leg raise test on the right. The physician diagnosed exacerbation of lumbar spine sprain with right L5 radiculopathy, exacerbation or right hip trochanteric bursitis, and lumbar sprain without radiculopathy. On 03/21/2014 the injured worker noted complaints of bilateral hand pain. The injured worker was allowed to return to work with restrictions; however, the work place was not able to place the injured worker with a position to accommodate the restrictions. Diagnostic imaging supporting

these diagnoses occurred on 10/03/10 and 04/11/2003. The request for authorization form and rationale were not presented for review within the documentation.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**PM&R (Physical Medicine & Rehabilitation) consult and treat:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Guidelines, Chapter 7 - Independent Medical Examinations and Consultations.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Forearm, Wrist, and Hand, Office Visits.

**Decision rationale:** The Official Disability Guidelines recommend office visits as determined to be medically necessary. Evaluation and management outpatient visits to the office of medical doctors play a critical role in the proper diagnosis and return to function of an injured worker, and they should be encouraged. 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 physician noted on 10/24/2013 improvement to pain and sleeps with conservative care including physical therapy, acupuncture, chiropractic care, and directed home health exercises and stretching. The final physician's visit was limited in objective documentation only indicating pain to the lumbar region radiating to the right lower extremity and a limited range of motion. Documentation has continued to note limited range of motion and pain with improvements from continuing conservative care and medications at each visit. There is a lack of documentation indicating the injured worker has deficits which would require a physical medicine and rehabilitation consultation and treatment would be indicated. As such, the request for PM&R (Physical Medicine & Rehabilitation) consult and treat is not medically necessary.