

Case Number:	CM15-0037573		
Date Assigned:	04/08/2015	Date of Injury:	02/25/2012
Decision Date:	05/06/2015	UR Denial Date:	02/17/2015
Priority:	Standard	Application Received:	02/26/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 49 year old male who sustained an industrial injury on 2/25/12 when while lifting a beam he felt a sharp pain in his lower back. He had MRI of the lumbar spine, then lumbar spinal fusion L4-5, L5-S1 (6/17/13). He went to the emergency department in approximately 5/14 for a flare up low back pain and was x-rayed and to continue the medication he was already on. Of note, he had a spinal injury in 1992 and he has been treated for low back pain 2006 through 2011 per documentation. He currently complains of low back pain that radiates to both legs. He is on multiple narcotic medications for pain but they are not mentioned by name. Diagnoses include lumbar disc degeneration with bulging L4-5 and L5 and S1; status post two level anterior lumbar fusion with SynFix device (6/16/13; recurrence of severe pain after return to work following successful fusion; diskogenic pain; lumbar radiculopathy; chronic pain syndrome. Treatments to date are medications and surgeries. Diagnostics include x-ray of the lumbar spine (7/16/14); MRI of the lumbar spine (1/30/12, 2013). In the progress note dated 1/12/15 the treating provider's plan of care does not mention a new patient visit 12/8/14 that Utilization Review denied, nor was it noted in any records available for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

New patient visit 12/8/14: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 2 General Approach to Initial Assessment and Documentation Page(s): 22.

Decision rationale: The patient presents with low back pain. The request is for NEW PATIENT VISIT 12/8/14. The request for authorization is not provided. The patient is status-post lumbar spine fusion, 06/17/13. MRI of the lumbar spine, 01/30/12, shows at L4-5 a stable circumferential disk bulge with mild to moderate degenerate facet arthropathy and ligamentum flavum thickening. He has had epidural injections. Patient is positive straight leg raise bilaterally. The patient is not working. ACOEM guidelines, Chapter 2, page 22 has the following regarding physician management of patients: "A focused medical history, work history, and physical examination generally are sufficient to assess the patient who complains of an apparently job-related disorder. The initial medical history and examination will include evaluation for serious underlying conditions, including sources of referred symptoms in other part of the body." Per UR letter dated, 03/02/15, treater's reason for the request is "he felt that CPT code 99203 was justified, as it was a new patient office visit." Most of the patient's information is provided by AME report dated, 07/16/14. In this case, CPT-99203 for new patient E/M requires three key components: Detailed history; Detailed examination; and Medical decision making of low complexity. Review of provided medical records for date of service, 12/08/14, shows only a one page "Doctor's First Report of Occupational Injury or Illness" is submitted. Treater hand writes, "CT 5/25/12 - 5/25/13; S/P L/S surg w/ rad to the legs; stat post Fusion; Request authorization for reviewing." Treater does not adequately meet the requirements of the three key components as required for CPT-99203. Therefore, the request IS NOT medically necessary.