

Case Number:	CM15-0090484		
Date Assigned:	05/14/2015	Date of Injury:	01/18/2008
Decision Date:	06/22/2015	UR Denial Date:	04/20/2015
Priority:	Standard	Application Received:	05/11/2015

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, Indiana, New York
 Certification(s)/Specialty: Internal Medicine

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 66 year old male who sustained a work related injury January 18, 2008, described as cumulative trauma. Past history included right carpal tunnel surgery and right trigger finger release February 2014, left knee arthroscopic repair 2008, diabetes, hypertension, and sleep apnea on CPAP (continuous positive airway pressure). According to an initial internal medicine evaluation, dated March 3, 2015, the injured worker presented with complaints of shortness of breath, decreased hearing bilaterally, lower back pain, neck pain, bilateral shoulder pain, bilateral hand pain, headaches, abdominal discomfort, change in bowel habits and depression and anxiety. He reports chemical and asbestos exposure at work. On physical examination, the lungs are clear to auscultation with tenderness to palpation at both costochondral junctions. The abdomen is soft, non-tender, non-distended without rebound or guarding and normal active bowel sounds. Diagnoses are type II diabetes with a history of peripheral neuropathy; hypertension; abdominal pain secondary to constipation; shortness of breath, rule out reactive airway disease versus COPD (chronic obstructive pulmonary disease). A primary treating physician's progress checklist and notes, dated March 25, 2015, finds the injured worker complaining of neck, lower back, bilateral shoulder, bilateral hand and wrist and right middle finger pain. He is not interested in injections /surgery for his industrial pain at this time. Diagnoses are cervical spine disc bulges; lumbar disc bulges with radiculopathy; possible right and left shoulder derangement; left carpal tunnel syndrome. At issue is the request for internal medicine evaluation and treatment.

IMR ISSUES, DECISIONS AND RATIONALES

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

Internal medicine evaluation and treatment every 4 weeks: 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), Pain, Office visits, ACOEM Guidelines Chapter 7, page 127.

MAXIMUS guideline: Decision based on MTUS ACOEM Page(s): Chapter 7, Pages 127-8. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain section, Office visits.

Decision rationale: Pursuant to the ACOEM and the Official Disability Guidelines, internal medicine evaluation and treatment every four weeks is not medically necessary. An occupational health practitioner may refer to other specialists if the diagnosis is certain or extremely complex, when psychosocial factors are present, or when the plan or course of care may benefit from additional expertise. A consultation is designed to aid in the diagnosis, prognosis and therapeutic management of a patient. The need for a clinical office visit with a healthcare provider is individualized based upon a review of patient concerns, signs and symptoms, clinical stability and reasonable physician judgment. The determination is also based on what medications the patient is taking, since some medications such as opiates for certain antibiotics require close monitoring. As patient conditions are extremely varied, a set number of office visits per condition cannot be reasonably established. Determination of necessity for an office visit requires individual case review and reassessment 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. In this case, the injured worker's working diagnoses are type II diabetes mellitus with history peripheral neuropathy; hypertension currently elevated; abdominal pain likely secondary to chronic constipation, maybe manifestation of irritable bowel syndrome; and shortness of breath rule out reactive airways disease versus chronic obstructive lung disease. The injured worker subjectively, according to a March 3, 2015 progress note, complaints of shortness of breath, hearing loss, neck, back and shoulder pain, headache and abdominal pain. The documentation indicates the injured worker had pulmonary function tests prior to the internal medicine consultation. The date of injury is January 18, 200. The injured worker states abdominal symptoms have been present for approximately 10 years. Abdominal pains associated with cramping and bloating. There is rare nausea but no vomiting. There is significant constipation and occasional loose stools. The symptoms are consistent with irritable bowel syndrome. The injured worker states shortness of breath has been present for 10-12 years. The injured worker has a 10-pack year history of tobacco use (quit 1973). There is questionable chemical exposure at work is an etiology for shortness of breath. There is no clinical indication or rationale in the treatment section for follow up visits every 4 weeks with the internal medicine consultant. Determination of necessity for an office visit requires individual case review and reassessment. A follow-up office visit is based upon clinical facts of the prior office visit based on history, physical assessment and impression. As noted above, there is no clinical indication or rationale in the treatment plan section of the progress note dated March 3, 2015 for internal medicine open-ended follow-up every four weeks. Consequently, absent clinical documentation with a clinical indication and rationale for a follow-up visit every four weeks, internal medicine evaluation and treatment every four weeks is not medically necessary.