

Case Number:	CM13-0027166		
Date Assigned:	11/22/2013	Date of Injury:	05/27/1994
Decision Date:	09/17/2014	UR Denial Date:	09/12/2013
Priority:	Standard	Application Received:	09/20/2013

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 Maryland. 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:

Mr. Stanley Gomez was 74 year old man injured from 05/07/1993 to 05/07/1994 and the mechanism of injury was not noted in the medical records. His past medical history included coronary artery disease, coronary artery bypass grafting as well as stent placement, anemia, hypertension, hyperlipidemia and GERD . Medications included Plavix, Avapro, Crestor, Lovaza, Coreg, Vytorin. On November 6,2012 stress test was done and it was negative for ischemia or chest pain. An echocardiogram done at the same time showed moderate aortic stenosis. On 05/29/13, he was seen by Cardiology and was found to be doing well. He denied chest pain or shortness of breath. His examination showed normal vital signs, mid peaking systolic ejection murmur and no edema. There were no laboratory data. He was advised to continue Plavix for his heart disease, Avapro and Coreg for hypertension, Atorvastatin and Lovaza for hyperlipidemia and was asked to follow up in 6 months. A request was made for laboratory examination including CMP, lipid panel, CBC with differential, hemoglobin A1c, PSA and urine analysis before a scheduled physical examination by the primary treating provider.

IMR ISSUES, DECISIONS AND RATIONALES

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

Complete metabolic panel without GFR: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 2 General Approach to Initial Assessment and Documentation.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Bakris GL, Weir MR. Angiotensin-converting enzyme inhibitor-associated elevations in serum creatinine: is this a cause for concern? Arch Intern Med 2000;160:685-93.

Decision rationale: According to guidelines, liver and renal function needs to be checked at least yearly in patients on ARBs and statins due to the risk of renal insufficiency, hyperkalemia and liver damage. There is no documentation of prior CMP testing. Hence the request for CMP is considered medically necessary.

Lipid panel (fasting specimen): Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 2 General Approach to Initial Assessment and Documentation.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: ATP III guidelines.

Decision rationale: The ATP III recommendations for monitoring of statin therapy are as follows: check lipid panel at baseline, 6-8 weeks after starting or adjusting the medication/dose, and then every 4-6 months; check LFTs at baseline, approximately 12 weeks after starting therapy, then annually or more frequently if indicated; and check creatine kinase (CK) at baseline and if the patient reports muscle soreness, tenderness, or pain [NCEP Adult Treatment Panel III, 2002]. In this particular case, medical records show no evidence of lab testing done in one year. Hence the request for followup lipid panel is medically necessary.

CBC with Diff.: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 2 General Approach to Initial Assessment and Documentation.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Drugs.com.

Decision rationale: This patient is on multiple medications including Plavix, Avapro, Lovaza and Atorvastatin. According to evidence cited above, CBC monitoring is appropriate given ongoing medication use including Plavix at least annually. Review of records show no previous results of CBC. Hence CBC testing is medically necessary.

Hemoglobin A1C: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 2 General Approach to Initial Assessment and Documentation.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: American diabetic association guidelines for screening for diabetes mellitus.

Decision rationale: ADA recommends screening adults for diabetes starting at age 45, or at an earlier age if they are overweight or obese and have one or more additional risk factors, such as being physically inactive, having hypertension, or a first-degree relative with diabetes. In this case there is no documentation of prior screening and hence a screening hemoglobin A1c is medically necessary.

PSA, total: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 2 General Approach to Initial Assessment and Documentation.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: American cancer society guidelines for prostate screening.

Decision rationale: ██████████ emphasizes the need for involving men in the decision whether to screen for prostate cancer. Men need to have sufficient information regarding the risks and benefits of screening and treatment to make an informed and shared decision; providing them with a decision aid may facilitate the decision-making process [46]. For men who decide to be screened, the ██████████ recommends PSA testing with or without DRE for average-risk men beginning at 50 years of age. Screening should not be offered to men with a life expectancy less than 10 years. Men whose initial PSA level is greater than or equal to 2.5 ng/mL should undergo annual testing; men with a lower initial level can be tested every two years. The guidelines also recommend beginning screening discussions at age 40 to 45 in patients at high-risk of developing prostate cancer (eg, black men and men with a first-degree relative with prostate cancer diagnosed before age 65). The guideline also recommends keeping the biopsy referral threshold at 4.0 ng/mL. However, for men with PSA levels from 2.5 to 4.0 ng/mL, the guideline encourages individualized decision making and assessment (<http://deb.uthscsa.edu/URORiskCalc/Pages/uroriskcalc.jsp>), which can include age, race, family history, digital rectal examination findings, previous biopsy results, and use of five alpha-reductase inhibitors. Based on above information and review of records, there is no baseline PSA and hence a screening PSA test is medically necessary.

UA (urinalysis): Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 2 General Approach to Initial Assessment and Documentation.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical

Evidence: Simerville J. Urinalysis: A comprehensive review. Am Fam Physician. 2005 Mar 15; 71 (6): 1153-1162.

Decision rationale: The employee had a history of coronary artery disease, hypertension, anemia and Gastroesophageal Reflux Disease (GERD). A urinalysis was being requested as part of work-up for a physical examination. According to the above article, routine urinalysis is not recommended as a routine screening tool except in women who may be pregnant. There were no urinary symptoms including hematuria, dysuria or frequency. Given the absence of symptoms, a urinalysis is not medically necessary or appropriate.