

Case Number:	CM13-0063045		
Date Assigned:	12/30/2013	Date of Injury:	08/03/2010
Decision Date:	04/11/2014	UR Denial Date:	11/13/2013
Priority:	Standard	Application Received:	12/09/2013

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 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 patient is 47 year old male who was injured on 8/3/10. The mechanism of injury is unknown. He has been evaluated for skin cancer. He has had a positive biopsy for squamous cell carcinoma. Prior treatment history has included excision of squamous cell carcinoma under frozen section control (7/16/13). Diagnostic studies reviewed include a comprehensive blood panel dated 3/5/13, and an M-Mode, 2D & Doppler echocardiography report dated 3/5/13. A clinic note dated 1/31/13 documented the patient to have complaints of left hip pain located anteriorly in left groin and laterally at greater trochanter. Objective findings on exam included gastrointestinal exam showing no palpable abdominal masses or bulging in the groin. There is no edema in the abdomen or groin. The abdomen is nontender on palpation. There is no palpable abdominal guarding. The groin is nontender. There is no rebound tenderness of the abdomen. A hernia is not identified on exam. A progress report dated 3/14/13 documents the patient with complaints of 2-3 years of GERD characterized by acid taste in mouth, occasional regurgitation, and burning in chest. This almost always happens at night when he is lying down. Objective findings on exam include pupils being equal, round, and reactive to light, extraocular movements are intact, and the oropharynx clear. Lungs are clear to auscultation bilaterally. Bowel sounds are present, soft, nontender, and nondistended. There is no hepatomegaly, and there are no masses. The impression is of a 47 year old male recently improved with dietary changes.

IMR ISSUES, DECISIONS AND RATIONALES

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

BLOOD WORK ONCE EVERY SIX MONTHS: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Guideline.gov.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Group Health Care, Hypertension Diagnosis and Treatment Guidelines, Follow-up/Monitoring (online).

Decision rationale: There is inadequate information provided to approve blood work done every 6 months. There should be further discussion of which blood tests and why they are clinically indicated for this patient. Further, blood work is usually ordered in conjunction with doctor visits. This patient could see the physician twice per year and have specific blood work ordered at that time. It is inappropriate and not within guidelines to order blood work 6 months in advance with no scheduled clinic visits. Given the above, the request is not certified.