Case Number:	CM14-0154451		
Date Assigned:	10/23/2014	**Date of Injury:**	06/15/2004
Decision Date:	11/21/2014	**UR Denial Date:**	08/27/2014
Priority:	Standard	**Application Received:**	09/22/2014

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 Occupational and Environmental Medicine, has a subspecialty in Public Health and is licensed to practice in West Virginia. 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:

This individual is a 53 year old female who sustained an industrially related injury on June 15 2004 involving her right wrist and arm. She has ongoing complaints of right arm and hand pain with accompanying paresthesia. The most recent physical examination provided in the available record indicates; tenderness in the right hand, a positive Finkelstein's, Tinel's and Phalen's Test on the right. Negative Tinel's is note at the right cubital tunnel. No atrophy noted in the hand or forearm, decreased sensation throughout the right hand with 4/5 strength and normal digital range of motion. Radiographs (unknown date); reveal cystic changes with narrowing of radio carpal and STT spaces. MRI - (date unknown), showed mild cuff tendonosis. There is a normal "nerve test" noted from 2004, but the results are not included and the type of test is not elaborated upon. It is noted that subjective systems of numbness and tingling in the right fingers (all fingers) have worsened since the time of the "nerve test". There are also notations in the available record indicating the use of steroid injections (location and date unknown), hand therapy (date unknown) and she is currently receiving acupuncture therapy which is reported as being efficacious. The record makes mention of a history of gout vs RA but does not elaborate. This individual is currently requesting EMG and NCV of upper right extremity as well as multiple labs (ANA, HLA, Uric Acid, ESR, C-RP) for rheumatologic evaluation.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI of the Right Wrist: 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 11 Forearm, Wrist, and Hand Complaints Page(s): 268-272. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Forearm, wrist and Hand, Magnetic Resonance Imaging

Decision rationale: ACOEM states, 'For most patients presenting with true hand and wrist problems, special studies are not needed until after a four- to six-week period of conservative care and observation. Most patients improve quickly, provided red flag conditions are ruled out. Exceptions include the following:- In cases of wrist injury, with snuff box (radial-dorsal wrist) tenderness, but minimal other findings, a scaphoid fracture may be present. Initial radiographic films may be obtained but may be negative in the presence of scaphoid fracture. A bone scan may diagnose a suspected scaphoid fracture with a very high degree of sensitivity, even if obtained within 48 to 72 hours following the injury". ODG states for a wrist MRI "Indications for Imaging -- Magnetic Resonance Imaging (MRI):- Acute hand or wrist trauma, suspect acute distal radius fracture, radiographs normal, next procedure if immediate confirmation or exclusion of fracture is required- Acute hand or wrist trauma, suspect acute scaphoid fracture, radiographs normal, next procedure if immediate confirmation or exclusion of fracture is required- Acute hand or wrist trauma, suspect gamekeeper injury (thumb MCP ulnar collateral ligament injury)- Chronic wrist pain, plain films normal, suspect soft tissue tumor- Chronic wrist pain, plain film normal or equivocal, suspect Kienbock's disease- Repeat MRI is not routinely recommended, and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology". The treating physician has provided no evidence of red flag diagnosis and has not met the above ODG and ACOEM criteria for an MRI of the wrist. Also a prior MRI is noted in the record. As such, the request for MRI of the right wrist is not medically necessary.

EMG of the Right Upper Extremity: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 260-262. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Electrodiagnostic Testing (EMG/NCS)

Decision rationale: ACOEM States "Appropriate electrodiagnostic studies (EDS) may help differentiate between CTS and other conditions, such as cervical radiculopathy. These may include nerve conduction studies (NCS), or in more difficult cases, electromyography (EMG) may be helpful." ODG states "Recommended needle EMG or NCS, depending on indications. Surface EMG is not recommended. Electromyography (EMG) and nerve conduction studies (NCS) are generally accepted, well-established and widely used for localizing the source of the neurological symptoms and establishing the diagnosis of focal nerve entrapments, such as carpal tunnel syndrome or radiculopathy, which may contribute to or coexist with CRPS II (causalgia), when testing is performed by appropriately trained neurologists or physical medicine and

rehabilitation physicians (improperly performed testing by other providers often gives inconclusive results). As CRPS II occurs after partial injury to a nerve, the diagnosis of the initial nerve injury can be made by electrodiagnostic studies". The treating physician does not document evidence of radiculopathy, muscle atrophy, and abnormal neurologic findings. The treating physician has not met the above ACOEM and ODG criteria for an EMG of the upper extremities. As such the request for EMG of the right upper extremity is not medically necessary.

NCV of the Right Upper Extremity: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 260-262. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Electrodiagnostic testing (EMG/NCS)

Decision rationale: ACOEM States "Appropriate electrodiagnostic studies (EDS) may help differentiate between CTS and other conditions, such as cervical radiculopathy. These may include nerve conduction studies (NCS), or in more difficult cases, electromyography (EMG) may be helpful." ODG states "Recommended needle EMG or NCS, depending on indications. Surface EMG is not recommended. Electromyography (EMG) and nerve conduction studies (NCS) are generally accepted, well-established and widely used for localizing the source of the neurological symptoms and establishing the diagnosis of focal nerve entrapments, such as carpal tunnel syndrome or radiculopathy, which may contribute to or coexist with CRPS II (causalgia), when testing is performed by appropriately trained neurologists or physical medicine and rehabilitation physicians (improperly performed testing by other providers often gives inconclusive results). As CRPS II occurs after partial injury to a nerve, the diagnosis of the initial nerve injury can be made by electrodiagnostic studies". The treating physician does not document evidence of radiculopathy, muscle atrophy, and abnormal neurologic findings. The treating physician has not met the above ACOEM and ODG criteria for an NCV of the upper extremities. As such the request for NCV of the right upper extremity is not medically necessary.

HLA Testing: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 208-214. Decision based on Non-MTUS Citation A) Lane SK, Gravel JW, Clinical Utility of Common Serum Rheumatologic Tests; Am. Fam. Physician. 2002 Mar 15;65(6):1073-1081 B) Moder KG1, Mason TG. The Current Use and Interpretation of Rheumatologic Tests Adolesc. Med. 1998 Feb.9(1):25-34

Decision rationale: ACOEM guidelines state "Erythrocyte sedimentation rate (ESR), complete blood count (CBC), and tests for autoimmune diseases (such as rheumatoid factor) can be useful to screen for inflammatory or autoimmune sources of joint pain. All of these tests can be used to confirm clinical impressions, rather than purely as a screening test in a "shotgun" attempt to clarify reasons for unexplained shoulder complaints." Given the over ten years since her documented industrial injury and the consistency of this individual's current symptoms with her documented injuries, screening for these disorders due to current complaints would not seem to be indicated. Per our other cited references; "Serum rheumatologic tests are generally most useful for confirming a clinically suspected diagnosis. Testing for rheumatoid factor is appropriate when rheumatoid arthritis, Sjogren's syndrome or cryoglobulinemia is suspected. Antinuclear antibody testing is highly sensitive for systemic lupus erythematosus and drug-induced lupus. Anti-double-stranded DNA antibodies correlate with lupus nephritis; the titer often corresponds with disease activity in systemic lupus erythematosus. Testing for anti-Ro (anti-SS-A) or anti-La (anti-SS-B) may help confirm the diagnosis of Sjogren's syndrome or systemic lupus erythematosus; these antibodies are associated with the extra glandular manifestations of Sjogren's syndrome. Cytoplasmic anti-neutrophil cytoplasmic antibody testing is highly sensitive and specific for Wegener's granulomatosis. Human leukocyte antigen-B27 is frequently present in ankylosing spondylitis and Reiter's syndrome, but the background presence of this antibody in white populations limits the value of testing. An elevated erythrocyte sedimentation rate (ESR) is a diagnostic criterion for polymyalgia rheumatic and temporal arteritis; however, specificity is quite low. ESR values tend to correlate with disease activity in rheumatoid arthritis and may be useful for monitoring therapeutic response." The treating physician makes no mention of clinical suspicion of any pf the above diagnoses. The symptoms this individual reports would seem to be specific for her known injury, given this and the additional information available in the provided records, there is little to base clinical suspicion of a rheumatologic disorder upon. The treating physician details no systemic symptoms consistent with a rheumatologic disorder and there is no description of the specific indication for this test. Even in the presence of a possible rheumatologic condition, the available record shows no attempt to relate any proposed rheumatologic illness to this individuals' industrial injury. As such the request for HLA testing is not medically necessary.

Lab: Chem 7: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 208-214,Chronic Pain Treatment Guidelines NSAIDs, Specific Drug List & Adverse Effects Page(s): 70.

Decision rationale: Per MTUS "Routine Suggested Monitoring: Package inserts for NSAIDs recommend periodic lab monitoring of a CBC and chemistry profile (including liver and renal function tests). The treating physician does not document the exact indication for this laboratory analysis. Presumably it is for evaluation of ongoing use of anti-inflammatories. However, while noted in the available record that anti-inflammatories have been used in the past there is no record of current use of anti-inflammatories, or any other medications for that matter. In the

absence of this information there does not seem to be an indication for this test. As such the request for a Chem 7 laboratory test is not medically necessary.

Lab: Rheumatoid Factor: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 208-214. Decision based on Non-MTUS Citation A) Lane SK, Gravel JW, Clinical Utility of Common Serum Rheumatologic Tests; Am. Fam. Physician. 2002 Mar 15;65(6):1073-1081 B) Moder KG1, Mason TG. The Current Use and Interpretation of Rheumatologic Tests Adolesc. Med. 1998 Feb. 9(1):25-34

Decision rationale: ACOEM guidelines state "Erythrocyte sedimentation rate (ESR), complete blood count (CBC), and tests for autoimmune diseases (such as rheumatoid factor) can be useful to screen for inflammatory or autoimmune sources of joint pain. All of these tests can be used to confirm clinical impressions, rather than purely as a screening test in a "shotgun" attempt to clarify reasons for unexplained shoulder complaints." Given the over ten years since her documented industrial injury and the consistency of this individual's current symptoms with her documented injuries, screening for these disorders due to current complaints would not seem to be indicated. Per our other cited references; "Serum rheumatologic tests are generally most useful for confirming a clinically suspected diagnosis. Testing for rheumatoid factor is appropriate when rheumatoid arthritis, Sjogren's syndrome or Cryoglobulinemia is suspected. Antinuclear antibody testing is highly sensitive for systemic lupus erythematosus and drug-induced lupus. Anti-double-stranded DNA antibodies correlate with lupus nephritis; the titer often corresponds with disease activity in systemic lupus erythematosus. Testing for anti-Ro (anti-SS-A) or anti-La (anti-SS-B) may help confirm the diagnosis of Sjogren's syndrome or systemic lupus erythematosus; these antibodies are associated with the extra glandular manifestations of Sjogren's syndrome. Cytoplasmic anti-neutrophil cytoplasmic antibody testing is highly sensitive and specific for Wegener's granulomatosis. Human leukocyte antigen-B27 is frequently present in ankylosing spondylitis and Reiter's syndrome, but the background presence of this antibody in white populations limits the value of testing. An elevated erythrocyte sedimentation rate (ESR) is a diagnostic criterion for polymyalgia rheumatica and temporal arteritis; however, specificity is quite low. ESR values tend to correlate with disease activity in rheumatoid arthritis and may be useful for monitoring therapeutic response." The treating physician makes no mention of clinical suspicion of any pf the above diagnoses. The symptoms this individual reports would seem to be specific for her known injury, given this and the additional information available in the provided records, there is little to base clinical suspicion of a rheumatologic disorder upon. The treating physician details no systemic symptoms consistent with a rheumatologic disorder and there is no description of the specific indication for this test. Even in the presence of a possible rheumatologic condition, the available record shows no attempt to relate any proposed rheumatologic illness to this individuals' industrial injury. As such the request for Rheumatoid Factor testing is not medically necessary.

Lab: Antinuclear Antibodies (ANA): Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 208-214. Decision based on Non-MTUS Citation A) Lane SK, Gravel JW, Clinical Utility of Common Serum Rheumatologic Tests; Am. Fam. Physician. 2002 Mar 15;65(6):1073-1081 B) Moder KG1, Mason TG. The Current Use and Interpretation of Rheumatologic Tests Adolesc. Med. 1998 Feb. 9(1):25-34

Decision rationale: ACOEM guidelines state "Erythrocyte sedimentation rate (ESR), complete blood count (CBC), and tests for autoimmune diseases (such as rheumatoid factor) can be useful to screen for inflammatory or autoimmune sources of joint pain. All of these tests can be used to confirm clinical impressions, rather than purely as a screening test in a "shotgun" attempt to clarify reasons for unexplained shoulder complaints." Given the over ten years since her documented industrial injury and the consistency of this individual's current symptoms with her documented injuries, screening for these disorders due to current complaints would not seem to be indicated. Per our other cited references; "Serum rheumatologic tests are generally most useful for confirming a clinically suspected diagnosis. Testing for rheumatoid factor is appropriate when rheumatoid arthritis, Sjogren's syndrome or cryoglobulinemia is suspected. Antinuclear antibody testing is highly sensitive for systemic lupus erythematosus and drug-induced lupus. Anti-double-stranded DNA antibodies correlate with lupus nephritis; the titer often corresponds with disease activity in systemic lupus erythematosus. Testing for anti-Ro (anti-SS-A) or anti-La (anti-SS-B) may help confirm the diagnosis of Sjogren's syndrome or Systemic Lupus Erythematosus; these antibodies are associated with the extra glandular manifestations of Sjogren's syndrome. Cytoplasmic anti-neutrophil cytoplasmic antibody testing is highly sensitive and specific for Wegener's granulomatosis. Human leukocyte antigen-B27 is frequently present in ankylosing spondylitis and Reiter's syndrome, but the background presence of this antibody in white populations limits the value of testing. An elevated erythrocyte sedimentation rate (ESR) is a diagnostic criterion for polymyalgia rheumatica and temporal arteritis; however, specificity is quite low. ESR values tend to correlate with disease activity in rheumatoid arthritis and may be useful for monitoring therapeutic response." The treating physician makes no mention of clinical suspicion of any pf the above diagnoses. The symptoms this individual reports would seem to be specific for her known injury, given this and the additional information available in the provided records, there is little to base clinical suspicion of a rheumatologic disorder upon. The treating physician details no systemic symptoms consistent with a rheumatologic disorder and there is no description of the specific indication for this test. Even in the presence of a possible rheumatologic condition, the available record shows no attempt to relate any proposed rheumatologic illness to this individuals' industrial injury. As such the request for ANA testing is not medically necessary.

Lab: C-Reactive Protein: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 208-214. Decision based on Non-MTUS Citation A) Lane SK, Gravel JW, Clinical Utility of Common Serum Rheumatologic Tests; Am. Fam. Physician. 2002 Mar 15;65(6):1073-1081 B) Moder KG1, Mason TG. The Current Use and Interpretation of Rheumatologic Tests Adolesc. Med. 1998 Feb. 9(1):25-34

Decision rationale: ACOEM guidelines state "Erythrocyte sedimentation rate (ESR), complete blood count (CBC), and tests for autoimmune diseases (such as rheumatoid factor) can be useful to screen for inflammatory or autoimmune sources of joint pain. All of these tests can be used to confirm clinical impressions, rather than purely as a screening test in a "shotgun" attempt to clarify reasons for unexplained shoulder complaints." Given the over ten years since her documented industrial injury and the consistency of this individual's current symptoms with her documented injuries, screening for these disorders due to current complaints would not seem to be indicated. Per our other cited references; "Serum rheumatologic tests are generally most useful for confirming a clinically suspected diagnosis. Testing for rheumatoid factor is appropriate when rheumatoid arthritis, Sjogren's syndrome or cryoglobulinemia is suspected. Antinuclear antibody testing is highly sensitive for systemic lupus erythematosus and drug-induced lupus. Anti-double-stranded DNA antibodies correlate with lupus nephritis; the titer often corresponds with disease activity in systemic lupus erythematosus. Testing for anti-Ro (anti-SS-A) or anti-La (anti-SS-B) may help confirm the diagnosis of Sjogren's syndrome or systemic lupus erythematosus; these antibodies are associated with the extra glandular manifestations of Sjogren's syndrome. Cytoplasmic anti-neutrophil cytoplasmic antibody testing is highly sensitive and specific for Wegener's granulomatosis. Human leukocyte antigen-B27 is frequently present in ankylosing spondylitis and Reiter's syndrome, but the background presence of this antibody in white populations limits the value of testing. An elevated erythrocyte sedimentation rate (ESR) is a diagnostic criterion for polymyalgia rheumatica and temporal arteritis; however, specificity is quite low. ESR values tend to correlate with disease activity in rheumatoid arthritis and may be useful for monitoring therapeutic response." The treating physician makes no mention of clinical suspicion of any pf the above diagnoses. The symptoms this individual reports would seem to be specific for her known injury, given this and the additional information available in the provided records, there is little to base clinical suspicion of a rheumatologic disorder upon. The treating physician details no systemic symptoms consistent with a rheumatologic disorder and there is no description of the specific indication for this test. Even in the presence of a possible rheumatologic condition, the available record shows no attempt to relate any proposed rheumatologic illness to this individuals' industrial injury. As such the request for C-RP testing is not medically necessary.

Lab: Sedimentation Rate: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 208-214. Decision based on Non-MTUS Citation A) Lane SK, Gravel JW, Clinical Utility of Common Serum Rheumatologic Tests; Am. Fam. Physician. 2002 Mar 15;65(6):1073-

1081 B) Moder KG1, Mason TG. The Current Use and Interpretation of Rheumatologic Tests Adolesc. Med. 1998 Feb. 9(1):25-34

Decision rationale: ACOEM guidelines state "Erythrocyte sedimentation rate (ESR), complete blood count (CBC), and tests for autoimmune diseases (such as rheumatoid factor) can be useful to screen for inflammatory or autoimmune sources of joint pain. All of these tests can be used to confirm clinical impressions, rather than purely as a screening test in a "shotgun" attempt to clarify reasons for unexplained shoulder complaints." Given the over ten years since her documented industrial injury and the consistency of this individual's current symptoms with her documented injuries, screening for these disorders due to current complaints would not seem to be indicated. Per our other cited references; "Serum rheumatologic tests are generally most useful for confirming a clinically suspected diagnosis. Testing for rheumatoid factor is appropriate when rheumatoid arthritis, Sjogren's syndrome or cryoglobulinemia is suspected. Antinuclear antibody testing is highly sensitive for systemic lupus erythematosus and drug-induced lupus. Anti-double-stranded DNA antibodies correlate with lupus nephritis; the titer often corresponds with disease activity in systemic lupus erythematosus. Testing for anti-Ro (anti-SS-A) or anti-La (anti-SS-B) may help confirm the diagnosis of Sjogren's syndrome or systemic lupus erythematosus; these antibodies are associated with the extra glandular manifestations of Sjogren's syndrome. Cytoplasmic anti-neutrophil cytoplasmic antibody testing is highly sensitive and specific for Wegener's granulomatosis. Human leukocyte antigen-B27 is frequently present in ankylosing spondylitis and Reiter's syndrome, but the background presence of this antibody in white populations limits the value of testing. An elevated erythrocyte sedimentation rate (ESR) is a diagnostic criterion for polymyalgia rheumatica and temporal arteritis; however, specificity is quite low. ESR values tend to correlate with disease activity in rheumatoid arthritis and may be useful for monitoring therapeutic response." The treating physician makes no mention of clinical suspicion of any pf the above diagnoses. The symptoms this individual reports would seem to be specific for her known injury, given this and the additional information available in the provided records, there is little to base clinical suspicion of a rheumatologic disorder upon. The treating physician details no systemic symptoms consistent with a rheumatologic disorder and there is no description of the specific indication for this test. Even in the presence of a possible rheumatologic condition, the available record shows no attempt to relate any proposed rheumatologic illness to this individuals' industrial injury. As such the request for ESR testing is not medically necessary.

Lab: Blood Uric Acid: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation A) Pagana KD, Pagana TJ (2010). Mosby's Manual of Diagnostic and Laboratory Tests, 4th ed. St. Louis: Mosby. B) Walter Siegenthaler ed. (2007). Differential Diagnosis in Internal Medicine: From Symptom to Diagnosis; Chap. 10 Arthropathies Associated with Metabolic diseases, New York: Thieme Publishers Series.

Decision rationale: Per the cited references; "Primary gout in men occurs about 10 times more often than in women. In men gout develops most frequently between the ages of 40 and 50 years, but in women usually only after the age of 60 years." "Classical acute gout is always very painful, it occurs during the night, and patients may not be able to walk on the inflamed joints. Typically, the involved joint is red, swollen, and extremely painful. Slightly raised temperatures, elevated ESR and, and leukocytosis are the rule. In radiographs, well-delineated erosions at the end of bones are characteristic for gout." The available medical records provide no indication that this individual is demonstrating any of the symptoms classically associated with gouty arthritis or gouty nephropathy. Further, there is no attempt by the treating physician to make an association between a diagnosis of gout and the industrial injury sustained by this individual. As such the request for blood uric acid testing is not medically necessary.

Lab: Cyclic Citorullinated Peptide (CCP), Antibody: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 208-214. Decision based on Non-MTUS Citation A) Lane SK, Gravel JW, Clinical Utility of Common Serum Rheumatologic Tests; Am. Fam. Physician. 2002 Mar 15;65(6):1073-1081 B) Moder KG1, Mason TG. The Current Use and Interpretation of Rheumatologic Tests Adolesc. Med. 1998 Feb. 9(1):25-34

Decision rationale: ACOEM guidelines state "Erythrocyte sedimentation rate (ESR), complete blood count (CBC), and tests for autoimmune diseases (such as rheumatoid factor) can be useful to screen for inflammatory or autoimmune sources of joint pain. All of these tests can be used to confirm clinical impressions, rather than purely as a screening test in a "shotgun" attempt to clarify reasons for unexplained shoulder complaints." Given the over ten years since her documented industrial injury and the consistency of this individual's current symptoms with her documented injuries, screening for these disorders due to current complaints would not seem to be indicated. Per our other cited references; "Serum rheumatologic tests are generally most useful for confirming a clinically suspected diagnosis. Testing for rheumatoid factor is appropriate when rheumatoid arthritis, Sjogren's syndrome or cryoglobulinemia is suspected. Antinuclear antibody testing is highly sensitive for systemic lupus erythematosus and drug-induced lupus. Anti-double-stranded DNA antibodies correlate with lupus nephritis; the titer often corresponds with disease activity in systemic lupus erythematosus. Testing for anti-Ro (anti-SS-A) or anti-La (anti-SS-B) may help confirm the diagnosis of Sjogren's syndrome or systemic lupus erythematosus; these antibodies are associated with the extra glandular manifestations of Sjogren's syndrome. Cytoplasmic anti-neutrophil cytoplasmic antibody testing is highly sensitive and specific for Wegener's granulomatosis. Human leukocyte antigen-B27 is frequently present in ankylosing spondylitis and Reiter's syndrome, but the background presence of this antibody in white populations limits the value of testing. An elevated erythrocyte sedimentation rate (ESR) is a diagnostic criterion for polymyalgia rheumatica and temporal arteritis; however, specificity is quite low. ESR values tend to correlate with disease activity in rheumatoid arthritis and may be useful for monitoring therapeutic response." The treating physician makes no mention of clinical suspicion of any pf the above diagnoses. The symptoms

this individual reports would seem to be specific for her known injury, given this and the additional information available in the provided records, there is little to base clinical suspicion of a rheumatologic disorder upon. The treating physician details no systemic symptoms consistent with a rheumatologic disorder and there is no description of the specific indication for this test. Even in the presence of a possible rheumatologic condition, the available record shows no attempt to relate any proposed rheumatologic illness to this individuals' industrial injury. As such the request for CCP testing is not medically necessary.

Lab: Serum Uric Acid: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation A) Pagana KD, Pagana TJ (2010). Mosby's Manual of Diagnostic and Laboratory Tests, 4th ed. St. Louis: Mosby. B) Walter Siegenthaler ed. (2007). Differential Diagnosis in Internal Medicine: From Symptom to Diagnosis; Chap. 10 Arthropathies Associated with Metabolic diseases, New York: Thieme Publishers Series.

Decision rationale: Per the cited references; "Primary gout in men occurs about 10 times more often than in women. In men gout develops most frequently between the ages of 40 and 50 years, but in women usually only after the age of 60 years." "Classical acute gout is always very painful, it occurs during the night, and patients may not be able to walk on the inflamed joints. Typically, the involved joint is red, swollen, and extremely painful. Slightly raised temperatures, elevated ESR and, and leukocytosis are the rule. In radiographs, well-delineated erosions at the end of bones are characteristic for gout." The available medical records provide no indication that this individual is demonstrating any of the symptoms classically associated with gouty arthritis or gouty nephropathy or demonstrating any of the traditional diagnostic markers. Further, there is no attempt by the treating physician to make an association between a diagnosis of gout and the industrial injury sustained by this individual. As such the request for serum uric acid testing is not medically necessary.