

<b>Case Number:</b>	CM14-0026267		
<b>Date Assigned:</b>	03/05/2014	<b>Date of Injury:</b>	09/01/2011
<b>Decision Date:</b>	12/03/2014	<b>UR Denial Date:</b>	02/10/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/27/2014

### 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 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:

The employee was a 59-year old male who sustained an industrial injury on 09/01/2011. His history was significant for cervical spine surgery on 05/07/13, hypertension, hyperlipidemia, sleep disorder, hearing loss, tinnitus, cephalgia, vertigo and psychiatric diagnosis. Medications included Vicodin, Tizanidine, Gabapentin and Amlodipine. The clinical note from 01/08/14 was reviewed. Subjective complaints included musculoskeletal pains, anxiety, depression, hearing loss and headaches. He was tolerating his medications well. Diagnoses included hypertension, controlled, traumatic brain injury, cephalgia/vertigo, hearing loss and sleep disorder. The plan of care included Amlodipine 2.5mg daily, echocardiogram, low cholesterol diet, CMP and lipid panel. The clinical note from 01/21/14 was reviewed. Subjective complaints included low back pain status post injections to the lower back with limited short term improvement and no long term improvement. Objective findings included a blood pressure of 130/88 mm of Hg, limited range of motion of lumbar spine, pain and tenderness of lumbar spine and lumbosacral junction, pain with extension and flexion of lumbar spine and positive straight leg raising test on right side. The diagnoses included cervical spine stenosis with multi-level disc herniation and myelomalacia, severe in nature, progressive cervical myelopathy secondary to the severe spinal stenosis, lumbar spine strain/sprain, hearing loss, tinnitus, dizziness, sleep difficulties, headaches, memory impairment, depression, neuropathy, lumbar spine radiculopathy and status post cervical spine surgery. The plan of care included Orthopedic spine consultation and Pain management followup.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**UPDATED LABS, CMP AND FASTING LIPD PANEL: Overturned**

**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 Other Medical Treatment Guideline or Medical Evidence: <http://www.uspreventiveservicestaskforce.org/uspstf/uspschol.htm>

**Decision rationale:** The employee was a 59-year old male who sustained an industrial injury on 09/01/2011. His history was significant for cervical spine surgery on 05/07/13, hypertension, hyperlipidemia, sleep disorder, hearing loss, tinnitus, cephalgia, vertigo and psychiatric diagnosis. Medications included Vicodin, Tizanidine, Gabapentin and Amlodipine. The clinical note from 01/08/14 was reviewed. Subjective complaints included musculoskeletal pains, anxiety, depression, hearing loss and headaches. He was tolerating his medications well. Diagnoses included hypertension, controlled, traumatic brain injury, cephalgia/vertigo, hearing loss and sleep disorder. The plan of care included Amlodipine 2.5mg daily, echocardiogram, low cholesterol diet, CMP and lipid panel. The request was for CMP and lipid panel. USPSTF strongly recommends screening men aged 35 and older for lipid disorder. The guidelines also recommend obtaining labs for chemistry panel in individuals with hypertension. The request for lipid panel and CMP is medically necessary and appropriate.