

Case Number:	CM14-0034129		
Date Assigned:	07/07/2014	Date of Injury:	12/11/2009
Decision Date:	10/02/2014	UR Denial Date:	02/25/2014
Priority:	Standard	Application Received:	03/19/2014

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 Family 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:

This 55-year old spray painter was diagnosed with aplastic anemia presumed to be due to work exposure, with a date of injury of 12/11/09. He was originally treated with conservative care and chemotherapy. He remained clinically stable until the end of 2011, then progressed to a preleukemic state called myelodysplastic syndrome. He underwent bone marrow transplantation for this condition. He was initially placed on Tacrolimus, Methotrexate and Prednisone to prevent graft versus host rejection. He made excellent progress, and his regimen was changed to low-dose Tacrolimus therapy daily, without other medications. By 8/13/12 he was considered to be essentially cured by his treating oncologist. He subsequently developed a kidney infection that was thought to be fungal, and which was treated with ongoing Mycophenolate. He retained normal kidney function. Throughout the course of this patient's illness he has been followed and treated by the same oncologist, who apparently continues to follow him. For unclear reasons, an internist who is also certified in Occupational Medicine began to follow him as primary provider at 6-week intervals beginning on 8/21/12, and continuing to the present. During that time this primary provider has ordered multiple lab tests which appear to be performed in his own lab, and has generated multiple reports. He does not appear to have made any therapeutic interventions at all, and his notes consistently recommending that the patient see the treating oncologist as part of the plan. A 10/17/13 UR Peer review modified a request for blood tests and a urinalysis by non-certifying the urinalysis and allowing for blood work to be performed only two more times at 6-month intervals. Per an 11/22/13 supplemental AME report, The AME is not clear what role the primary provider is playing in the patient's care since he has offered no treatments, and the physician who actually manages the patient's care is his oncologist. The AME was of the opinion that continued visits with the primary provider were unnecessary and wasteful. A 1/29/14 PR2 from the primary provider documents that the patient feels about the same, with intermittent

headaches and some weakness. The partially illegible note states that the patient's lungs are clear and that he has a II/VI systolic murmur. Treatment plan includes Tacrolimus 0.5 mg every day, Mycophenolate 500 mg twice per day, and low-dose aspirin every day. The patient is to see his oncologist for follow up. The PR2 states that no diagnostic tests were ordered. However there is an accompanying request for authorization of the same date for extensive blood work (see individual tests requested on the following page). No rationale for the testing was included in either document. The testing was non-certified in UR on 2/25/14. A request for IMR of this decision was generated on 3/17/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

Blood work (metabolic panel, CBC, lipid panel, hepatic function pane, hemoglobin A1C, thyroid panel, uric acid, GGTP, serum ferritin, vitamin D, and apolipoprotein A/B):

Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation British committee for standards in hematology. Guidelines for the diagnosis and management of aplastic anemia. Dr J Haematol. 2009 Oct;147 (1) :43-70

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: UptoDate, an online evidence-based review service for clinicians (www.uptodate.com), Laboratory Assessment of Thyroid Function, and Screening for Lipid Disorders

Decision rationale: The treating physician in this case continues to order numerous and frequent tests which appear to be performed in his own laboratory. There are results from previous lab tests in the records, done 8/28/13 and 10/9/13. Both sets of results contained some abnormal values, which resulted in absolutely no action by the treating physician. A previous UR performed 10/17/13 stated that he was authorized to perform laboratory testing two more times, including the test performed 10/9/13, and that the tests should be performed six months apart. The provider obviously ignored these instructions, and is requesting another set of labs less than four months from those drawn 10/9/13. An AME evaluator commented that he feels continued visits with the primary provider are unnecessary and wasteful. There is no rationale given for any of the tests ordered. A diagnosis of "anemia, unspecified" is recorded on the date the labs were requested, but the patient clearly no longer has anemia. The patient is being followed by an oncologist at a large medical center for any problems that might occur after his bone marrow transplant. It is highly unlikely that the oncologist would use laboratory results performed in the primary provider's lab to make any decision regarding the patient's care. There does not appear to be any reason for the primary provider to be performing any laboratory testing at all, let alone frequent and elaborate testing. In this setting, it is impossible to guess why each test is being performed, and to provide evidence-based references for each possible reason. A relatively simple example involves the ordered thyroid panel. Thyroid tests are usually ordered to screen for or to monitor thyroid disease. In this case, since the patient does not have a diagnosis of

thyroid disease, it can be presumed that a thyroid panel is being ordered to screen for thyroid disease. Per the reference cited above, thyroid tests should be ordered in patients who have symptoms or signs suggestive of thyroid disease, and the appropriate screening test is a TSH level. Further testing should be ordered if the TSH level is high, or if it is normal and the patient continues to have signs and symptoms of thyroid disease. Therefore, repeatedly and frequently ordering a panel that contains six different thyroid tests in a patient with no documented concern for thyroid disease, as is being done in this case, is medically unwarranted. Another example involves the lipid panel and apolipoprotein A and B levels ordered, which are screening tests for lipid disorders. The reference cited above states that lipid screening should be done in patients with a risk for cardiovascular (CV) events that is high enough to justify therapy with statins or aspirin. Usually a total cholesterol level and an HDL-C level are sufficient to assess CV risk. Measurement of Apolipoproteins A1 and B does not contribute significantly to the assessment of CV risk. The available clinical records in this case contain cholesterol and HDL levels that place the patient at average risk for CV events. There was no medical reason to perform these tests twice, and certainly not to repeat them regularly. There was never a good medical reason to order Apolipoprotein levels. The possible reasons for ordering most of the other tests on the list above are too numerous to discuss. A final point, however, is that even if the provider had given an appropriate reason for ordering a test, there would still be no medical necessity for it if he did not plan to act on the results. The previously performed tests contained several abnormal results, including high alkaline phosphatase (part of the liver panel) and high GGT. The treating physician did not comment on these results or take any action regarding them in subsequent visits. It can therefore be stated that the testing was medically unnecessary, as any future testing that this provider does is likely to be. Based on the clinical findings in this case and the citations above, blood work which includes a metabolic panel, CBC, lipid panel, hepatic function panel, hemoglobin A1C, thyroid panel, uric acid, GGTP, serum ferritin, vitamin D, and apolipoprotein A/B is not medically indicated. It is not medically necessary because the same tests have been recently performed, because the requesting provider has given no rationale for ordering them, and because they would not be indicated in the cases where a likely rationale can be presumed.