

<b>Case Number:</b>	CM14-0059747		
<b>Date Assigned:</b>	07/09/2014	<b>Date of Injury:</b>	10/25/2011
<b>Decision Date:</b>	09/24/2014	<b>UR Denial Date:</b>	04/03/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/30/2014

### 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 Geriatrics and is licensed to practice in New York. 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 injured worker is a 47 year old man with a date of injury of 10/25/11. He was being treated for asthma and obstructive sleep apnea. He also has a history of diabetes and hypertension. He used oxygen via nasal cannula and CPAP for his sleep apnea nocturnally. He was seen in 12/2013 and had labs performed including normal TSH, hemoglobin A1C at 7% (elevated), normal complete blood count, chemistries with elevation of random glucose consistent with his diagnosis of diabetes. He was seen by his psychiatry physician on 3/10/14 and continued to struggle with depression. He was seen by his pulmonary physician on 3/26/14 with complaints of headaches, wheezing, vertigo and coughing. His blood sugar log was reviewed. His review of systems was essentially negative other than for his presenting complaints. His blood pressure was 138/88 and his lung exam showed scattered rhonchi with expiratory wheezes. His abdominal exam was normal. His BMI was 29.42. At issue in this review is the request for the following laboratory studies: CBC with diff, CMP Mg Po4, INR/PTT, TSH, HbA 1c, Lipid profile, CRP, ESR and BNP.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Lab CBC with diff, CMP Mg Po4, INR/PTT, TSH, HbA 1c, Lipid profile, CRP, ESR & BNP: 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: Lab / blood work / hypertension: The Seventh Report of the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure.

**Decision rationale:** His prior lab work in 11/2013 was essentially normal except for a slightly elevated hemoglobin A1C. Per the Seventh Report of the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure, once antihypertensive drug therapy is initiated, serum potassium and creatinine should be monitored at least 1-2 times per year. His physical exam showed an abnormal lung exam and his blood pressure was slightly elevated. He had no cardiac, hepatic or esophageal symptoms documented. There were no historical or exam findings for toxicity or side effects of his medications. He has no history of thyroid disease. He already had extensive lab studies drawn within the prior few months and the medical necessity or clinical reasoning to justify why the blood work is needed is not substantiated in the records. As such, the request is not medically necessary.