

<b>Case Number:</b>	CM14-0188730		
<b>Date Assigned:</b>	11/19/2014	<b>Date of Injury:</b>	05/21/2012
<b>Decision Date:</b>	01/07/2015	<b>UR Denial Date:</b>	10/28/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/12/2014

### 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 is a 44 year old male patient who sustained a work related injury on 5/21/12. The exact mechanism of injury was not specified in the records provided. The current diagnoses include lumbosacral sprain/strain, L4-5 lumbar disc herniation, lumbar facet arthropathy and left lumbar radiculitis. Per the doctor's note dated 10/6/14, patient has complaints of distress and frustration, pain of left leg radiculopathy at 6-7/10, headache and palpitation. Physical examination revealed blood pressure 135/101, pulse 99, vital signs were stable, moderate tenderness to palpation over the bilateral L4-5 and L5-S1 lumbar facet region, muscular guarding over the left gluteus maximus region, range of motion of the lumbar spine limited between 60 to 70% with guarding and 5/5 strength. The current medication lists include Norco, Ultram, gabapentin and Celexa. The patient has had MRI scan dated 8/6/12 that revealed lumbar facet arthropathy at L5-S1 with significant degenerative disc disease at L5-S1; X-rays of the lumbar spine on January 2, 2014 that revealed 2.3mm of retrolisthesis of L4/5; MRI scan of the lumbar spine dated December 19, 2013 that revealed an annular tear L4-5 with disc extrusion at this level and severe compression of the left exiting L4 nerve root. He underwent a radiofrequency ablation treatment for his lumbar spine facet joints on 9/25/14 and had received a left knee injection. He had a urine drug toxicology report on 3/13/14 that was negative for opioids.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Lab work to include; complete blood count, lipid panel, total T3, T4 T3 uptake, T3 free, free thyroxine, venipuncture, basic metabolic panel, uric acid, GGTP, serum ferritin,**

**vitamin D 25 hydroxy, apollpoprotein A and B, urine creatinine, urine microalbumin:**  
Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS, specific drug list & adverse effects Page(s): 70.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Routine Suggested Monitoring Page(s): 70.

**Decision rationale:** A CMP (or BMP) can be ordered as part of a routine physical examination, or may be used to monitor a patient with a chronic disease, such as diabetes mellitus or hypertension. Per the cited guidelines, "Routine Suggested Monitoring: Package inserts for NSAIDs recommend periodic lab monitoring of a CBC and chemistry profile (including liver and renal function tests). There has been a recommendation to measure liver transaminases within 4 to 8 weeks after starting therapy, but the interval of repeating lab tests after this treatment duration has not been established....." As per records provided patient had blood pressure 135/101, pulse 99 and vital signs were stable. The patient has elevated blood pressure. The patient's current medication list does not include NSAIDS. Evidence of previous renal or thyroid pathology or a history of dyslipidemia, was not specified in the records provided. History or clinical evidence of vitamin D deficiency or iron deficiency was not specified in the records provided. Evidence of intolerance or GI symptoms of peptic ulcer with any previous use of NSAIDs was not specified in the records provided. The duration of previous use of NSAIDs was not specified in the records provided. Previous lab reports were not specified in the records provided. The rationale for a complete blood count, lipid panel, total T3, T4 T3 uptake, T3 free, free thyroxine, venipuncture, basic metabolic panel, uric acid, GGTP, serum ferritin, vitamin D 25 hydroxy, apolipoprotein A and B, urine creatinine, urine microalbumin was not specified in the records provided. The medically necessity of the request was not fully established in this patient at this time and is therefore, not medically necessary.