

<b>Case Number:</b>	CM15-0004988		
<b>Date Assigned:</b>	01/16/2015	<b>Date of Injury:</b>	11/28/2011
<b>Decision Date:</b>	03/25/2015	<b>UR Denial Date:</b>	12/16/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/09/2015

### 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: New York, Tennessee

Certification(s)/Specialty: Emergency Medicine

### 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 53-year-old male, with a reported date of injury of 11/28/2011. The diagnoses include lumbar post-laminectomy syndrome, low back pain, lumbar sprain, spinal stenosis of lumbar region, lumbosacral spondylosis without myelopathy, thoracic back sprain, degeneration of lumbar intervertebral disc, displacement of lumbar intervertebral disc without myelopathy, and sciatica. Treatments have included chiropractic treatment, L3-4 laminectomy, oral medications, sacroiliac joint injection, and physical therapy. The medical report dated 12/16/2014 indicates that the injured worker had low back pain. The pain radiated to the left ankle, left calf, left foot, and left thigh. He may have another lumbar spine surgery. The treating physician requested six office visits, a follow-up visit regarding chronic low back pain, and routine labs. On 12/26/2014, Utilization Review (UR) denied the request for office visit times six, follow-up visit (date of service 12/16/2014), routine complete blood count (CBC), chemistry panel, thyroid-stimulating hormone (TSH), prostate-specific antigen (PSA), testosterone levels, urinalysis, urine drug screen twice a year, and random urine drug screen. The UR physician noted that there was no rationale for so many monthly visits being clearly medically necessary and it was not clear what the results of the previous labs had been. The MTUS Guidelines have been cited.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Office visit x 6, follow up visit:** 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 Pain Interventions and Guidelines Official Disability Guidelines (ODG): Low back, Lumbar & Thoracic

**Decision rationale:** Office visits are recommended as determined to be medically necessary. Evaluation and management (E&M) outpatient visits to the offices of medical doctor(s) play a critical role in the proper diagnosis and return to function of an injured worker, and they should be encouraged. The need for a clinical office visit with a health care provider is individualized based upon a review of the patient concerns, signs and symptoms, clinical stability, and reasonable physician judgment. The determination is also based on what medications the patient is taking, since some medicines such as opiates, or medicines such as certain antibiotics, require close monitoring. As patient conditions are extremely varied, a set number of office visits per condition cannot be reasonably established. The determination of necessity for an office visit requires individualized case review and assessment, being ever mindful that the best patient outcomes are achieved with eventual patient independence from the health care system through self care as soon as clinically feasible. Codes for Automated approval are for six outpatient visits for an established patient. For opioid use frequency of visits while in the trial phase (first 6 months) is every 2 weeks for the first 2 to 4 months and then at approximate 1 to 2-month intervals. In this case the patient has no urgent condition or significant change in his condition that would require additional visits. There is no indication for monthly visits as this patient is established. The request should not be authorized.

**Routine CBC, chem panel, TSH, PSA, testosterone levels, UA, UDS twice a year & random UDS:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Pain Interventions and Guidelines Page(s): 78. Decision based on Non-MTUS Citation UpToDate: Preoperative medical evaluation of the healthy patient UpToDate: Laboratory assessment of thyroid function UpToDate: Overview of testosterone deficiency in older men UpToDate: Screening for prostate cancer Official Disability Guidelines- Pain: Urine drug testing

**Decision rationale:** Complete blood count is a blood test that gives information on hemoglobin, white blood cells, and platelets. Anemia is present in approximately 1 percent of asymptomatic patients. The frequency of significant unsuspected white blood cell or platelet abnormalities is low. Chem panel is a blood test that measures renal function, blood glucose, and electrolytes. Mild to moderate renal impairment is usually asymptomatic; the prevalence of an elevated creatinine among asymptomatic patients with no history of renal disease is only 0.2 percent. The

frequency of unexpected electrolyte abnormalities is low (0.6 percent in one report). The frequency of glucose abnormalities increases with age; almost 25 percent of patients over age 60 had an abnormal value in one report. Urinalysis is indicated when screening for urinary tract infection in symptomatic patients and for screening for renal disease. Serum thyroid-stimulating hormone (TSH) concentration is used to assess thyroid function. Testosterone levels are indicated if a man has symptoms or conditions that suggest testosterone deficiency, such as decreased libido, energy, or mood, or osteoporosis or anemia. Although screening for prostate cancer with PSA can reduce mortality from prostate cancer, the absolute risk reduction is very small. Given limitations in the design and reporting of the randomized trials, there remain important concerns that the benefits of screening are outweighed by the potential harms to quality of life, including the substantial risks for overdiagnosis and treatment complications. In this case there is no documentation that the patient is suffering from symptoms of anemia, electrolyte abnormality, renal dysfunction, diabetes, testosterone deficiency, thyroid disease, or prostate disease. There is no medical indication for the blood test. The request should not be authorized. Chronic Pain Medical Treatment Guidelines state that urinary drug testing should be used if there are issues of abuse, addiction, or pain control in patients being treated with opioids. ODG criteria for Urinary Drug testing are recommended for patients with chronic opioid use. Patients at low risk for addiction/aberrant behavior should be tested within 6 months of initiation of therapy and yearly thereafter. Those patients with moderate risk for addiction/aberrant behavior should undergo testing 2-3 times/year. Patients with high risk of addiction/aberrant behavior should be tested as often as once per month. In this case there is no indication that the patient is exhibiting addiction/aberrant behavior. Urine drug testing is indicated annually. The request should not be authorized.