

Case Number:	CM15-0143385		
Date Assigned:	08/04/2015	Date of Injury:	12/03/2014
Decision Date:	09/01/2015	UR Denial Date:	07/01/2015
Priority:	Standard	Application Received:	07/23/2015

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: California, Indiana, New York
 Certification(s)/Specialty: Internal 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 an 18 year old female patient who sustained an industrial injury on December 03, 2014. A recent primary treating office visit dated May 04, 2015 reported the patient with subjective complaint of left knee pains after having slipped and fallen at work. The assessment found the patient with cellulitis of the knee; a body mass index between 19-24, adult; and knee contusion. She was given Bactrim DS, and will obtain laboratory work up and follow up in two weeks. That follow up visit dated May 12, 2015 found the patient being treated for left knee septic arthritis with a STAT referral to an infectious disease physician. The patient is temporarily totally disabled. Of note, on March 13, 2015 she was seen in an emergency room and treated with intravenous antibiotics. The knee was also aspirated, cultured, and arthroscopically irrigated and debrided. A recent therapy note dated June 15, 2015 reported the patient progressing slowly, continues to have severe restriction with knee flexion and extension. There is mild pain and tenderness upon stretching. The plan of care recommends focusing on stretching and strengthening, joint mobilization, balance and gait training. An infectious disease visit dated June 22, 2015 reported the left knee still with limited range of motion, without cellulitis, no mobile fluid collection noted, some tenderness with firm palpation particularly over the patellar and patellar tendon surface. The plan is to undergo rheumatology evaluation and reassess the need for antibiotic therapy.

IMR ISSUES, DECISIONS AND RATIONALES

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

Labs & Cardio-respiratory testing: CMPR (comprehensive metabolic panel R): 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 History and physical assessment Page(s): 5-6.

Decision rationale: Pursuant to the Chronic Pain Medical Treatment Guidelines, labs and cardio respiratory testing; CMPR (comprehensive metabolic panel R is not medically necessary. Thorough history taking is always important in the clinical assessment and treatment planning for the patient with chronic pain and includes a review of medical records. Clinical recovery may be dependent on identifying and addressing previously unknown or undocumented medical or psychosocial issues. A thorough physical examination is also important to establish/confirm diagnoses and observe/understand pain behavior. The history and physical examination serves to establish reassurance and patient confidence. Diagnostic studies should be ordered in this context and community is not simply for screening purposes. In this case, the injured worker's working diagnosis is abdominal pain in the requesting providers June 4, 2015 progress note. The date of injury is December 3, 2014. The request for authorization is June 4, 2015. The injured worker is a 19-year-old woman that fell on the job December 3, 2014. An injury was sustained to the left knee. The worker developed a septic left knee joint and urinary tract infection. The injured worker was hospitalized for IV antibiotics May 2015. The injured worker had two biopsies of the knee and the joint cleanout. The injured worker is taking intravenous vancomycin daily. The requesting physician [REDACTED] saw the patient for the first time on June 4, 2015. According to the discussion section of the June 4, 2015 progress note, the injured worker continued to complain of abdominal pain. The worker was being evaluated for gastropathy and irritable bowel syndrome secondary to stress. The documentation indicates the use of pain medications may have contributed to gastrointestinal difficulties. The injured worker is unable to recall nonsteroidal anti-inflammatory drugs by name or narcotics by name. The requesting provider requested labs and cardiorespiratory testing for further evaluation. The treating provider additionally requested medical records from [REDACTED].

[REDACTED] There is no clinical indication or rationale for [REDACTED] to be ordering a vancomycin peak and trough level. The progress note by the requesting provider does not state the infectious disease provider who is managing the infectious disease and vancomycin. A review of the medical record shows vancomycin levels throughout. Additionally, there are several metabolic comprehensive profiles throughout the medical record. Specifically on May 27, 2015 a comprehensive metabolic profile was performed that was unremarkable. On June 30, 2015 a comprehensive metabolic profile was performed that was unremarkable with borderline sodium of 134. There is no clinical indication or rationale for repeating a comprehensive metabolic profile when review of the medical record shows 2 recent metabolic profiles performed within the last 7 to 10 days. The treating provider ordered a chronic Beryllium disease blood test. There is no clinical indication or rationale in the requesting provider's documentation for this blood test. The requesting provider [REDACTED] discusses abdominal pain, gastropathy and possible irritable bowel syndrome is differential diagnosis. There is a rheumatologist involved in the

injured worker's care. There is an infectious disease specialist involved in the injured worker's care. There is an orthopedist involved in the injured worker's care. The treating provider has not reviewed the medical record prior to ordering comprehensive metabolic profile testing. Consequently, absent compelling clinical documentation for a comprehensive metabolic profile with two comprehensive metabolic profiles performed within the prior 10 days and a clinical indication and rationale for ordering a repeat comprehensive metabolic profile without first reviewing the entire medical record, labs and cardio respiratory testing; CMPR (comprehensive metabolic panel R is not medically necessary.

Labs & Cardio-respiratory testing: CBD (Chronic beryllium disease): 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 History and physical assessment Page(s): 5-6.

Decision rationale: Pursuant to the Chronic Pain Medical Treatment Guidelines, lab and cardiorespiratory testing; CBD (chronic beryllium disease) is not medically necessary. Thorough history taking is always important in the clinical assessment and treatment planning for the patient with chronic pain and includes a review of medical records. Clinical recovery may be dependent on identifying and addressing previously unknown or undocumented medical or psychosocial issues. A thorough physical examination is also important to establish/confirm diagnoses and observe/understand pain behavior. The history and physical examination serves to establish reassurance and patient confidence. Diagnostic studies should be ordered in this context and community is not simply for screening purposes. In this case, the injured worker's working diagnosis is abdominal pain in the requesting provider's June 4, 2015 progress note. The date of injury is December 3, 2014. The request for authorization is June 4, 2015. The injured worker is a 19-year-old woman that fell on the job December 3, 2014. An injury was sustained to the left knee. The worker developed a septic left knee joint and urinary tract infection. The injured worker was hospitalized for IV antibiotics May 2015. The injured worker had two biopsies of the knee and the joint cleanout. The injured worker is taking intravenous vancomycin daily. The requesting physician [REDACTED] saw the patient for the first time on June 4, 2015. According to the discussion section of the June 4, 2015 progress note, the injured worker continued to complain of abdominal pain. The worker was being evaluated for gastropathy and irritable bowel syndrome secondary to stress. The documentation indicates the use of pain medications may have contributed to gastrointestinal difficulties. The injured worker is unable to recall nonsteroidal anti-inflammatory drugs by name or narcotics by name. The requesting provider requested labs and cardiorespiratory testing for further evaluation. The treating provider additionally requested medical records from [REDACTED]. There is no clinical indication or rationale for the requesting provider ([REDACTED]) to be ordering a vancomycin peak and trough level. The progress note by the requesting provider does not state the infectious disease provider who is managing the infectious disease and Vancomycin dosing. A review of the medical record shows vancomycin levels throughout. Additionally, there are several metabolic comprehensive profiles throughout the medical record. Specifically on May 27, 2015 a comprehensive metabolic profile was performed that was unremarkable. On

June 30, 2015 a comprehensive metabolic profile was performed that was unremarkable with borderline sodium of 134. There is no clinical indication or rationale for repeating a comprehensive metabolic profile when review of the medical record shows 2 recent metabolic profiles performed within the last 7 to 10 days. The treating provider ordered a chronic Beryllium disease blood test. There is no clinical indication or rationale in the requesting provider's documentation for this blood test. The requesting provider [REDACTED] discusses abdominal pain, gastropathy and possible irritable bowel syndrome as differential diagnosis. There is a rheumatologist involved in the injured worker's care. There is an infectious disease specialist involved in the injured worker's care. There is an orthopedist involved in the injured worker's care. The requesting provider has not reviewed the medical record prior to ordering chronic beryllium disease testing. Consequently, absent compelling clinical documentation for chronic beryllium disease and a clinical indication and rationale for ordering chronic beryllium disease workup without first reviewing the entire medical record, labs and cardio respiratory testing; CBD (chronic beryllium disease) is not medically necessary.

Labs & Cardio-respiratory testing: Vancomycin levels: 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 History and physical assessment Page(s): 5-6.

Decision rationale: Pursuant to the Chronic Pain Medical Treatment Guidelines, lab and cardio respiratory testing; vancomycin levels are not medically necessary. Thorough history taking is always important in the clinical assessment and treatment planning for the patient with chronic pain and includes a review of medical records. Clinical recovery may be dependent on identifying and addressing previously unknown or undocumented medical or psychosocial issues. A thorough physical examination is also important to establish/confirm diagnoses and observe/understand pain behavior. The history and physical examination serves to establish reassurance and patient confidence. Diagnostic studies should be ordered in this context and community is not simply for screening purposes. In this case, the injured worker's working diagnosis is abdominal pain in the requesting providers June 4, 2015 progress note. The date of injury is December 3, 2014. The request for authorization is June 4, 2015. The injured worker is a 19-year-old woman that fell on the job December 3, 2014. An injury was sustained to the left knee. The worker developed a septic left knee joint and urinary tract infection. The injured worker was hospitalized for IV antibiotics May 2015. The injured worker had two biopsies of the knee and the joint cleanout. The injured worker is taking intravenous vancomycin daily. The requesting physician [REDACTED] saw the patient for the first time on June 4, 2015. According to the discussion section of the June 4, 2015 progress note, the injured worker continued to complain of abdominal pain. The worker was being evaluated for gastropathy and irritable bowel syndrome secondary to stress. The documentation indicates the use of pain medications may have contributed to gastrointestinal difficulties. The injured worker is unable to recall non-steroidal anti-inflammatory drugs by name or narcotics by name. The requesting provider requested labs and cardio respiratory testing for further evaluation. The treating provider additionally requested medical records from [REDACTED]

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