

Case Number:	CM15-0163780		
Date Assigned:	09/01/2015	Date of Injury:	02/01/2013
Decision Date:	10/13/2015	UR Denial Date:	08/10/2015
Priority:	Standard	Application Received:	08/20/2015

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
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 47 year old female with an industrial injury dated 02-01-2013. The injury is documented as occurring when a box fell on her neck. Her diagnoses included left shoulder pain and strain, left wrist sprain-contusion and carpal tunnel. Prior treatment included injections in shoulder, medications, home exercise program and physical therapy. She presents on 05-28-2015 with complaints of pain and numbness in left hand that radiates into her shoulders and neck. Physical exam revealed positive Phalen's and Tinel's. Range of motion was 60%. The request for hematology report was not listed on the application. The treatment request is for: Uric acid, Sed rate, RA panel, Lyme disease panel, Complete chem panel, CBC, C-reactive protein.

IMR ISSUES, DECISIONS AND RATIONALES

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

CBC: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines-Treatment in Workers' Compensation, Low Back Chapter.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Lumbar & Thoracic/Preoperative lab testing.

Decision rationale: The request is for lab testing. The Official Disability Guidelines state the following regarding this topic: Recommended as indicated below. Preoperative additional tests are excessively ordered, even for young patients with low surgical risk, with little or no interference in perioperative management. Laboratory tests, besides generating high and unnecessary costs, are not good standardized screening instruments for diseases. The decision to order preoperative tests should be guided by the patient's clinical history, comorbidities, and physical examination findings. Preoperative routine tests are appropriate if patients with abnormal tests will have a preoperative modified approach (i.e., new tests ordered, referral to a specialist or surgery postponement). Testing should generally be done to confirm a clinical impression, and tests should affect the course of treatment. (Feely, 2013) (Sousa, 2013) Criteria for Preoperative lab testing: Preoperative urinalysis is recommended for patients undergoing invasive urologic procedures and those undergoing implantation of foreign material. Electrolyte and creatinine testing should be performed in patients with underlying chronic disease and those taking medications that predispose them to electrolyte abnormalities or renal failure. Random glucose testing should be performed in patients at high risk of undiagnosed diabetes mellitus. In patients with diagnosed diabetes, A1C testing is recommended only if the result would change perioperative management. A complete blood count is indicated for patients with diseases that increase the risk of anemia or patients in whom significant perioperative blood loss is anticipated. Coagulation studies are reserved for patients with a history of bleeding or medical conditions that predispose them to bleeding, and for those taking anticoagulants. In this case, lab testing is not indicated. This is secondary to poor documentation of qualifying criteria as listed above. As such, the request is not medically necessary.

Complete chem panel: Upheld

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impression, and tests should affect the course of treatment. (Feely, 2013) (Sousa, 2013) Criteria for Preoperative lab testing: Preoperative urinalysis is recommended for patients undergoing invasive urologic procedures and those undergoing implantation of foreign material. Electrolyte and creatinine testing should be performed in patients with underlying chronic disease and those taking medications that predispose them to electrolyte abnormalities or renal failure. Random glucose testing should be performed in patients at high risk of undiagnosed diabetes mellitus. In patients with diagnosed diabetes, A1C testing is recommended only if the result would change perioperative management. A complete blood count is indicated for patients with diseases that increase the risk of anemia or patients in whom significant perioperative blood loss is anticipated. Coagulation studies are reserved for patients with a history of bleeding or medical conditions that predispose them to bleeding, and for those taking anticoagulants. In this case, lab testing is not indicated. This is secondary to poor documentation of qualifying criteria as listed above. As such, the request is not medically necessary.

Uric acid: Upheld

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C-reactive protein: Upheld

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RA panel: Upheld

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Decision rationale: The request is for lab testing. The Official Disability Guidelines state the following regarding this topic: Recommended as indicated below. Preoperative additional tests

are excessively ordered, even for young patients with low surgical risk, with little or no interference in perioperative management. Laboratory tests, besides generating high and unnecessary costs, are not good standardized screening instruments for diseases. The decision to order preoperative tests should be guided by the patient's clinical history, comorbidities, and physical examination findings. Preoperative routine tests are appropriate if patients with abnormal tests will have a preoperative modified approach (i.e., new tests ordered, referral to a specialist or surgery postponement). Testing should generally be done to confirm a clinical impression, and tests should affect the course of treatment. (Feely, 2013) (Sousa, 2013) Criteria for Preoperative lab testing: Preoperative urinalysis is recommended for patients undergoing invasive urologic procedures and those undergoing implantation of foreign material. Electrolyte and creatinine testing should be performed in patients with underlying chronic disease and those taking medications that predispose them to electrolyte abnormalities or renal failure. Random glucose testing should be performed in patients at high risk of undiagnosed diabetes mellitus. In patients with diagnosed diabetes, A1C testing is recommended only if the result would change perioperative management. A complete blood count is indicated for patients with diseases that increase the risk of anemia or patients in whom significant perioperative blood loss is anticipated. Coagulation studies are reserved for patients with a history of bleeding or medical conditions that predispose them to bleeding, and for those taking anticoagulants. In this case, lab testing is not indicated. This is secondary to poor documentation of qualifying criteria as listed above. As such, the request is not medically necessary.

Lyme disease panel: Upheld

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Sed rate: Upheld

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