

Case Number:	CM15-0169221		
Date Assigned:	09/09/2015	Date of Injury:	09/18/2007
Decision Date:	10/08/2015	UR Denial Date:	07/28/2015
Priority:	Standard	Application Received:	08/27/2015

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: Iowa, Illinois, Hawaii

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine, Public Health & General Preventive 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 70-year-old male who sustained an industrial injury on September 18, 2007 resulting in low back pain. Diagnoses have included degenerative disc disorder, sciatica, radiculopathy, bulging disc, and spinal stenosis. Physician report of June 22, 2015 states he also has Allergy Syndrome and Obstructive Sleep Apnea. Documented past treatment for lumbar diagnoses include laminectomy and spinal fusion with instrumentation L5-S1 in 2011, physical therapy, chiropractic treatments, acupuncture, and epidural injections, but the injured worker has presented with increasing symptoms of radiating low back pain. The treating physician's plan of care includes L4-5 laminectomy and posterior spinal fusion with instrumentation, and he requested blood work prior to surgery including immune system diagnostic tests ANA, ESR, ACE level and Anti DS DNA, which was non-certified on July 28, 2015 due to lack of positive imaging or patient history supporting necessity.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 Blood work to include ANA, ESR, ACE Level and Anti DS DNA: Overturned

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 uptodate, Primary coccidioidal infection and Approach to the adult with interstitial lung disease.

Decision rationale: Uptodate states in reference to coccidioidal infection: "Patient Monitoring - Regardless of whether treatment is instituted, immediately following diagnosis, patients are seen in follow-up every two to four weeks. During the weeks to months following presentation, respiratory symptoms (eg, cough and pleurisy) and systemic signs (eg, weight loss, night sweats, and fever) typically markedly diminish or resolve. Once such improvement has occurred, intervals between clinic visits are usually extended to every three to six months for up to two years (especially in those who are treated with antifungals [71]) to document radiographic resolution and identify any evidence of pulmonary or extrapulmonary complications [13].....Serial serologic testing for complement fixing-type anti-coccidioidal antibodies should be repeated at least once several weeks after the initial diagnosis, since a rise in antibody concentrations may be associated with progressive disease [72]. Although the original descriptions of this test noted that titers greater than 1:16 were often found in patients with disseminated infection, this correlation is now less reliable due to differences in commercial assays. Serologic studies may also be compromised in patients with altered immunity (transplant patients or HIV-infected patients) [1]. In patients who have a positive *Coccidioides* antigen test, which sometimes occurs in those with extensive disease, we typically repeat this test every one to two months until it becomes negative. We use it to confirm that the burden of disease is being reduced by treatment. It should not be used to determine timing of discontinuation of therapy since patients require continued therapy even after this test has become negative." Additionally, in relation to interstitial lung disease "Laboratory Tests - The routine laboratory evaluation typically includes biochemical tests to evaluate hepatic and renal function; hematologic tests with differential blood count to check for evidence of anemia, polycythemia, leukocytosis, or eosinophilia; urinalysis; and creatine kinase for myositis (table 4) [1]. Depending on the clinical situation and results of hepatic function tests, hepatitis serology and HIV testing may be appropriate. Serologic studies are obtained to ensure that hypersensitivity pneumonitis and subclinical connective tissue disease are not overlooked. However, not all patients with positive serologic tests will develop a well-differentiated connective tissue disease. We typically obtain a hypersensitivity precipitin panel, anti-nuclear antibodies (ANA), rheumatoid factor, anti-topoisomerase (anti-Scl70), and anti-neutrophil cytoplasmic antibodies (ANCA) [2]. We also obtain anti-JO-1 antibodies even in the absence of clinical myositis, as ILD precedes the onset of myositis in about 70 percent of patients with the anti-synthetase syndrome [3]. (See "Interstitial lung disease in dermatomyositis and polymyositis: Clinical manifestations and diagnosis".) For patients with a positive ANA, we usually obtain anti-double-stranded DNA and anti-extractable nuclear antigen antibodies (anti-Sm, anti-ribonucleoprotein) to further evaluate for systemic lupus erythematosus and mixed connective tissue disease. (See "Measurement and clinical significance of antinuclear antibodies" and "Antibodies to double-stranded (ds) DNA, Sm, and U1 RNP".) For patients presenting with pulmonary hemorrhage, we typically test for antiglomerular basement membrane antibodies, ANCA, ANA, antiphospholipid antibodies, and antistreptococcal antibodies. (See "The diffuse alveolar hemorrhage syndromes", section on 'Clues to a specific etiology'.) We generally do not find it helpful diagnostically to obtain a C-

reactive protein level or a sedimentation rate, as these are entirely nonspecific. Hypergammaglobulinemia is commonly observed in patients with ILD, but is also non-diagnostic. (See 'Acute phase reactants'.) The patient has a history of coccidiosis infection and interstitial lung disease. Per update it's appropriate for interstitial lung disease to monitor autoimmune and inflammatory markers. As such, the request for 1 Blood work to include ANA, ESR, ACE Level and Anti DS DNA is medically necessary.