

Case Number:	CM15-0185748		
Date Assigned:	09/25/2015	Date of Injury:	01/11/2001
Decision Date:	11/06/2015	UR Denial Date:	09/02/2015
Priority:	Standard	Application Received:	09/21/2015

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:

This 55 year old male sustained an industrial injury on 1-11-01. Documentation indicated that the injured worker was receiving treatment for gastroesophageal reflux disease, irritable bowel syndrome, hypertension, hyperlipidemia, osteoarthritis, vitamin D deficiency, valvular disease and status post cerebrovascular accident. Previous treatment included physical therapy, aqua therapy, acupuncture, epidural steroid injections and medications. Past medical history was significant for cerebrovascular accident with right sided hemiparesis (November 2013, renal cancer and right nephrectomy). In a PR-2 dated 8-18-15, the injured worker noted "controlled" gastroesophageal reflux disease with medication and controlled irritable bowel syndrome and hypertension. The injured worker stated that he slept five hours a night and awoke three times. The injured worker reported that he continued to follow a healthy diet and had not noticed any recent weight changes. Physical exam was remarkable for lungs clear to auscultation, heart with regular rate and rhythm and soft abdomen with normoactive bowel sounds. The injured worker was alert, oriented, pleasant and cooperative with blood pressure 148 over 96mm HG, heart rate 68 beats per minute, height 5'10" and weight 277 pounds. A body composition study was performed during the office visit. The treatment plan included a cardiology consultation and keeping a blood pressure diary. On 9-2-15, Utilization Review noncertified a request for a body composition study.

IMR ISSUES, DECISIONS AND RATIONALES

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

Body Composition Study: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009. Decision based on Non-MTUS Citation Official Disability Guidelines; Work Loss Data Institute, LLC; Corpus Christi, TX; www.odg-twc.com; Appendix A: ODG Workers' Compensation Drug Formulary (updated 4/30/2015).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Introduction.

Decision rationale: Pursuant to the Chronic Pain Medical Treatment Guidelines, body composition study 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 diagnoses are lumbar sprain strain; esophageal reflux; irritable bowel syndrome; obstructive sleep apnea; ganglion and cyst of synovium; unspecified essential hypertension. Date of injury is January 11, 2001. Request for authorization is August 28, 2015. According to a progress note dated August 26, 2015, the treating provider dictated an online review of medical records regarding a body composition report dated August 18, 2015. The specifics of the body composition study are enumerated in the report. The injured worker has a BMI of 39.7 which was elevated, a phase angle of 6.5 which is decreased, a basal metabolic rate of 2209.2 kcal which is elevated and a daily energy expenditure of 4639.4 kcal. There is no clinical indication or rationale in the medical record for the body composition study. The treating provider states the above medical information appears valid from an internal medicine standpoint. There is no clinical indication or rationale for the body composition study in the medical record. Based on clinical information in the medical record, peer-reviewed evidence-based guidelines, and no clinical indication or rationale for the body composition study, body composition study is not medically necessary.