

Case Number:	CM15-0043440		
Date Assigned:	03/13/2015	Date of Injury:	11/29/2010
Decision Date:	05/01/2015	UR Denial Date:	02/19/2015
Priority:	Standard	Application Received:	03/06/2015

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, West Virginia, Pennsylvania
 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 57 year old female patient, who sustained an industrial injury on 11/29/2010. The first report of occupational illness dated 04/27/2011 showed subjective complaints of both cervical and lumbar spine pain. In addition, she had complaint of right leg pains. She required a cane for ambulation. The following diagnoses were applied: lumbar spine strain, right ankle pain, and depression/stress. The plan of care involved: continuing medications Fioricet, Tramadol, Naproxen, Flurbiprophen, Prilosec, acupuncture and chiropractic therapy, obtain magnetic resonance imaging of lumbar spine, right hip and knee and a heat therapy unit, and obtain a psychiatric evaluation. Documentation provided gave the oldest office visit of 07/28/2014 which showed a pain management follow up performed. The patient is with subjective complaint of neck and low back pain. She reports having had run out of medications and is requesting more. She is prescribed Benazepril, Vicodin, Ibuprophen and Cymbalta. As well as using Buprenorphine. The following diagnostic impressions were noted: cervical spine discogenic disease at C3-4 and C4-5, lumbar spine discogenic disease at L4-5 and L5-S1, lumbar radiculopathy, anxiety/depression and chronic pain syndrome. The plan of care involved continuing with medications, recommending Butrans patch and Norco; along with verbal advisement of requiring to find a new pain management provider. Prior treatment to include: pain management, epidural injections, decompressive neuroplasty, and oral medications. The most current office visit dated 01/06/2015, reported subjective complaints of increasing headache and depression. Recommending group therapy and follow up in one month.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lab Tests: Pylori igG; CBC, CMP, HbA1C, UA, TFT, T4: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 70.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Nsaids, suggested monitoring Page(s): 70.

Decision rationale: Guidelines state that package inserts for NSAIDs recommend routine monitoring of a CBC and chemistry profile and monitoring liver transaminases within 4-8 weeks after starting therapy. In this case, whether or not the patient is taking NSAIDs and for how long is not specified in the records. Evidence of other diseases such as diabetes and hypertension was not documented. The request for pylori igg, cbc, cmp, HbA1C, U/A, TFT, and T4 is not medically necessary and appropriate.