

Case Number:	CM15-0083290		
Date Assigned:	05/05/2015	Date of Injury:	07/28/2004
Decision Date:	06/10/2015	UR Denial Date:	04/01/2015
Priority:	Standard	Application Received:	04/30/2015

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, Tennessee
 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:

This is a 63 year old male with a July 28, 2004 date of injury. At the time (March 6, 2015) of the most recent evaluation submitted for review, there is documentation of subjective findings (intermittent lower back pain with an average rating of 5/10; radiation to the posterior lower extremities, right worse than left; numbness in the S1 distribution with prolonged walking), objective findings (slow but normal gait; range of motion decreased throughout the lumbosacral spine in all planes due to pain; tenderness to palpation throughout the lumbosacral spine and paraspinals with paralumbar muscle spasms; point tenderness of the sacroiliac joint and gluteal area reproducing pain in the low back on the right and left; normal motor strength throughout the lower extremities; equal and symmetrical reflexes in all extremities), current diagnoses (lumbago status post L5-S1 fusion; sacroiliac sprain, right and left; chronic pain not elsewhere classified), and treatments to date (back surgery; physical therapy; medications; spine injections; chiropractic adjustments; home exercise; transcutaneous electrical nerve stimulator unit). The medical record identifies that the injured worker is not currently taking any medications, and that employment is restricted due to pain. The treating physician documented a plan of care that included sacroiliac joint injections and bloodwork.

IMR ISSUES, DECISIONS AND RATIONALES

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

Unknown Blood Test: Upheld

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: Preoperative medical evaluation of the healthy patient.

Decision rationale: Complete blood count is a blood test that gives information on hemoglobin, white blood cells, and platelets. Anemia is present in approximately 1 percent of asymptomatic patients. The frequency of significant unsuspected white blood cell or platelet abnormalities is low. Chem panel is a blood test that measures renal function, blood glucose, and electrolytes. Mild to moderate renal impairment is usually asymptomatic; the prevalence of an elevated creatinine among asymptomatic patients with no history of renal disease is only 0.2 percent. The frequency of unexpected electrolyte abnormalities is low (0.6 percent in one report). The frequency of glucose abnormalities increases with age; almost 25 percent of patients over age 60 had an abnormal value in one report. In this case the patient has history of chronic liver disease and chronic low back pain. Documentation in the medical record does not support suspicion for anemia, diabetes, electrolyte imbalance, or renal disease. The blood test requested is not documented. The lack of documentation does not allow determination of efficacy or safety. The request is not medically necessary.