Case Number:	CM14-0210336		
Date Assigned:	02/03/2015	**Date of Injury:**	10/29/2012
Decision Date:	03/04/2015	**UR Denial Date:**	11/18/2014
Priority:	Standard	**Application Received:**	12/15/2014

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: Pennsylvania
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:

The injured worker is a 48 year old female with a date of injury of 10/29/12. The mechanism of injury was noted to be cumulative orthopedic injury. Diagnoses include left shoulder impingement syndrome, bilateral wrist sprain/strain, cervical spine discopathy, carpal tunnel syndrome, and supinator syndrome/posterior interosseous nerve entrapment of the left upper extremity. The injured worker also had a history of hypertension, diabetes, obesity, hyperlipidemia, fatty liver associated with metabolic syndrome, stroke, heart murmur, arrhythmia, anxiety, depression, and alcohol use. Treatment included surgery to the cervical spine with fusion in 2012. An ambulatory blood pressure report of 5/23/13 showed elevated blood pressure. A physician's note from 8/20/13 notes symptoms of palpitations and discusses diagnostic testing including laboratory studies that showed elevated liver enzymes and triglycerides and normal thyroid studies and hepatitis screening, electrocardiogram showing sinus rhythm, echocardiogram showing mild mitral regurgitation and pulmonary regurgitation, a 24 hour Holter monitor showing atypical runs, and abdominal sonogram showing fatty infiltration of the liver. The physician documented a plan for lab work every 6 to 12 months to evaluate fatty liver. At a visit with the primary treating physician on 10/31/14, the injured worker reported continued pain in the neck, left shoulder, and bilateral wrists, rated 8/10 in severity. Examination showed tenderness over the cervical spinous processes and paraspinal muscles, positive Spurling's test bilaterally, tenderness over the acromioclavicular joint, subacromial joint, deltoid and posterior left shoulder with positive supraspinatus test on the left and decreased range of motion of the shoulder, and tenderness over both wrists with a ganglion cyst of the left wrist

and positive Tinel's test bilaterally. Work status was temporarily totally disabled. A secondary treating physician's review of records on 11/18/14 noted an electrocardiogram report from 12/10/13 that was within normal limits and laboratory reports from 12/10/13 showing increased glucose, increased triglycerides, increased hemoglobin A1C, and positive test for Helicobacter pylori. Medications as of 11/18/14 were noted to include clonidine, hydrochlorthiazide, carvedilol, diltiazem, and ibuprofen. On 11/18/14, Utilization review non-certified requests for multiple laboratory studies, electrocardiogram and rhythm electrocardiogram, stating that guidelines do not support the requests as medical necessity has not been established and that there was a history of hypertension but no documentation of vital signs or medications.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lab: Lipid panel this panel: 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 Rosenson, Robert S. et al, Measurement of blood lipids and lipoproteints, in UpToDate, edited by Ted. W. Post, published by UpToDate in Waltham, MA, 2015.

Decision rationale: The MTUS and ODG are silent with regard to lipid testing in the absence of statin therapy. The documentation from the physician notes a diagnosis of hyperlipidemia, and prior laboratory studies were noted to show increased triglycerides. Formal reports of prior laboratory testing with specific results were not provided, but a physician progress note documented elevated triglycerides on testing done 12/10/13. The history also included fatty liver, and a physician progress note documented a plan for laboratory testing every 6-12 months. A fasting lipid profile is recommended when screening for lipid abnormalities and for continued monitoring including monitoring of therapy, with testing performed every 6 to 12 months. The request for lipid panel is medically necessary.

Lab: Thyroxine, free: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 15 Stress Related Conditions Page(s): p. 396-397. Decision based on Non-MTUS Citation Ross, Douglas et al, Laboratory assessment of thyroid function, in UpToDate, edited by Ted. W. Post, published by UpToDate in Waltham, MA, 2015.

Decision rationale: The injured worker had diagnoses of anxiety and depression. There was no documentation of history of thyroid issues, and the the documentation from 8/20/13 notes that thyroid studies were normal. Per the MTUS, regarding diagnostic testing in the context of stress-

related conditions, history and physical examination should be used to evaluate for serious diseases such as thyroid or endocrine disorders, and exhaustive testing should be avoided. There were no historical or physical exam findings to suggest the presence of thyroid disease. Upon review of the medical records, there was no indication of why thyroid laboratory testing was requested. Screening in patients at risk of having thyroid disease should begin with measurement of the serum thyroid stimulating hormone (TSH). Measurement of serum free thyroxine is indicated when drugs or illness may alter the concentration of binding proteins with T4 and the free and total hormone concentrations may not be concordant, when the TSH is abnormal, when pituitary or hypothalamic disease is suspected, and when the patient has convincing symptoms of hyper- or hypothyroidism despite a normal TSH result. There were no indications provided to support the measurement of free thyroxine. There was no documentation of signs or symptoms of thyroid disease, pituitary disease, or hypothalamic disease, or abnormal results of TSH testing. The request for laboratory testing of free thyroxine is not medically necessary.

Lab Triiodothyroine T3; free: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 15 Stress Related Conditions Page(s): p. 396-397. Decision based on Non-MTUS Citation Ross, Douglas et al, Laboratory assessment of thyroid function, in UpToDate, edited by Ted. W. Post, published by UpToDate in Waltham, MA, 2015.

Decision rationale: The injured worker had diagnoses of anxiety and depression. There was no documentation of history of thyroid issues, and the documentation from 8/20/13 notes that thyroid studies were normal. Per the MTUS, regarding diagnostic testing in the context of stress-related conditions, history and physical examination should be used to evaluate for serious diseases such as thyroid or endocrine disorders, and exhaustive testing should be avoided. There were no historical or physical exam findings to suggest the presence of thyroid disease. Upon review of the medical records, there was no indication of why thyroid laboratory testing was requested. Screening in patients at risk of having thyroid disease should begin with measurement of the serum thyroid stimulating hormone (TSH). Measurement of serum free triiodothyronine (T3) is indicated when drugs or illness may alter the concentration of binding proteins with T3 and the free and total hormone concentrations may not be concordant, and when the TSH is low, to determine the degree of hyperthyroidism. There were no indications provided to support the measurement of free triiodothyronine (T3). There was no documentation of signs or symptoms of thyroid disease, or abnormal results of TSH testing. The request for laboratory testing of free triiodothyronine (T3) is not medically necessary.

Lab: Sedimentation rate: Overturned

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): p. 207-209.

Decision rationale: The injured worker has a history of left shoulder impingement syndrome with continued shoulder pain. Physician progress notes document shoulder joint tenderness and decreased range of motion. Per the MTUS, an erythrocyte sedimentation rate, complete blood count, and tests for autoimmune diseases (such as rheumatoid factor) can be useful to screen for inflammatory or autoimmune sources of joint pain. The request for sedimentation rate is medically necessary.

Lab: microsomal antibodies (eg, thyroid or liver-kidney): 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 Heneghan, Michael et al, Serologic markers of autoimmune hepatitis, in in UpToDate, edited by Ted. W. Post, published by UpToDate in Waltham, MA, 2015. Ross, Douglas et al, Laboratory assessment of thyroid function, in UpToDate, edited by Ted. W. Post, published by UpToDate in Waltham, MA, 2015.

Decision rationale: The MTUS and ODG are silent with regard to microsomal antibody testing. Several antibodies against thyroid antigens have been described in chronic autoimmune thyroiditis. There was no documentation of a history of autoimmune thyroiditis. Routine measurement of antithyroid antibodies is not necessary for the assessment of thyroid function. The injured worker had no history of thyroid disease and prior thyroid testing was noted to be normal. Anti-liver kidney microsomal-1 antibodies are autoantibodies present in type 2 autoimmune hepatitis and may also be seen in chronic hepatitis C, halothane-induced hepatitis, and graft versus host disease. There was no documentation of a history of autoimmune hepatitis, hepatitis C, halothane-induced hepatitis, or graft versus host disease. There was a history of fatty liver but there was no documentation of suspicion of autoimmune or infectious hepatitis. The indication for microsomial antibodies (eg, thyroid or liver-kidney) was not provided and the specific laboratory testing being requested was not noted. The request for microsomal antibodies (eg thyroid or liver-kidney) is not medicallly necessary.

Lab: Thyroglobulin antibody: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 15 Stress Related Conditions Page(s): p. 396-397. Decision based on Non-MTUS Citation Ross, Douglas et al, Laboratory assessment of thyroid function, in UpToDate, edited by Ted. W. Post, published by UpToDate in Waltham, MA, 2015.

Decision rationale: The injured worker had diagnoses of anxiety and depression. There was no documentation of history of thyroid issues, and the documentation from 8/20/13 notes that thyroid studies were normal. Per the MTUS, regarding diagnostic testing in the context of stress-related conditions, history and physical examination should be used to evaluate for serious diseases such as thyroid or endocrine disorders, and exhaustive testing should be avoided. There were no historical or physical exam findings to suggest the presence of thyroid disease. Upon review of the medical records, there was no indication of why thyroid laboratory testing was requested. Screening in patients at risk of having thyroid disease should begin with measurement of the serum thyroid stimulating hormone (TSH). Several antibodies against thyroid antigens have been described in chronic autoimmune thyroiditis. There was no documentation of a history of autoimmune thyroiditis. Routine measurement of antithyroid antibodies is not necessary for the assessment of thyroid function. The request for thyroglobulin antibody testing is not medically necessary.

Hepatitis screening: 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 Friedman, Lawrence et al, Approach to the patient with abnormal liver biochemical and function tests, in UpToDate, edited by Ted. W. Post, published by UpToDate in Waltham, MA, 2015.

Decision rationale: The initial evaluation of a patient with abnormal liver biochemical and function tests (LFTs) includes obtaining a history to identify potential risk factors for liver disease and performing a physical examination to look for clues to the etiology and for signs of chronic liver disease. Subsequent testing is determined based on the information gathered from the history and physical examination as well as the pattern of LFT abnormalities. The injured worker had a history of metabolic syndrome with fatty liver supported by findings on abdominal ultrasound, and elevated liver enzymes attributed to this. There was documentation of elevated liver enzymes and negative screening tests for hepatitis in August of 2013; specific results of more recent laboratory testing were not provided. The physician documentation noted that the injured worker denied use of recreational drugs. There was no documentation of potential exposure to hepatitis. The request for hepatitis screening is not medically necessary.

Diagnostic: rhythm ECG, one to three leads; with interpretation and report: 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 Zimetbaum, Peter et al., Overview of palipitations in adults, in UpToDate, edited by Ted. W. Post, published by UpToDate in Waltham, MA, 2015.

Decision rationale: The diagnostic of palpitations should include a detailed history, physical examination, and 12-lead electrocardiography. The documentation from the physician noted that the injured worker had a history of palpitations, arrhythmia, and abnormal Holter monitor showing "atypical runs" in August of 2013. There was no documentation of recent symptoms of palpitations or any cardiac signs and symptoms. No cardiac examination was provided. The most recent electrocardiogram of December 2013 was reported as normal. The request for rhythm ECG, one to three leads; with interpretation and report is not medically necessary.

Diagnostic: Electrocardiogram, routine ECG: 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 Low back chapter: preoperatative electrocardiogram Meisel, James et al, Diagnostic approach to chest pain in adults, in UpToDate, edited by Ted. W. Post, published by UpToDate in Waltham, MA, 2015.

Decision rationale: The ODG addresses electrocardiograms in the context of preoperative assessment. A preoperative electrocardiogram is recommended for patients undergoing high risk surgery and those undergoing intermediate risk surgery who have additional risk factors. There was no documentation of plan for any upcoming surgery. Electrocardiogram is used in the office evaluation of chest pain. The injured worker had a history of arrhythmia, cardiac murmur, and hypertension. Documentation noted results of echocardiogram showing mitral and pulmonary regurgitation, and several notations of electrocardiograms previously performed being normal and showing sinus rhythm, with the most recent electrocardiogram discussed being performed in December 2013. There was no documentation of recent cardiac signs or symptoms including chest pain or palpitations. The specific indication for performance of another electrocardiogram was not provided. The request for electrocardiogram, routine ECG is not medically necessary.