

<b>Case Number:</b>	CM15-0110104		
<b>Date Assigned:</b>	06/16/2015	<b>Date of Injury:</b>	01/10/2010
<b>Decision Date:</b>	07/15/2015	<b>UR Denial Date:</b>	05/19/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/08/2015

### 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:

January 10, 2010. The injury was sustained when the injured worker fell from an 8 foot shelving onto the concrete floor. The injured worker landed on the back and ruptured the spleen and suffered internal bleeding. The injured worker also suffered contusions and multiple spine damage. The injured worker previously received the following treatments cervical spine MRI, lumbar spine MRI, 20 sessions of psychotherapy, 3-4 epidural steroid injections with moderate relief, one facet joint injection, Zoloft, Ambien, Nabumetone, Percocet, Robaxin, Aleve, Vicodin and Flexeril; Ultram and Butrans were stopped due to limited effectiveness. The Flexeril was stopped due to the Soma worked better. On April 22, 2014 the injured worker underwent radiofrequency ablation bilateral L3, facet nerve and radiofrequency ablation bilateral L3, L4 and L5 facet nerves. The injured worker was diagnosed with lumbar radiculopathy, low back pain, neck pain, ruptured sleep, status post splenectomy, insomnia, sexual dysfunction, GERD (gastroesophageal reflux disease), diarrhea, headaches, hypertension, depression, dermatitis, polyuria and obesity. According to progress note of May 6, 2015, the injured workers chief complaint was low back pain. The injured worker rated at 1 out of 10 with pain mediation and without 7 out of 10. The injured worker was having poor quality of sleep. The injured worker's activity level had increased. The injured worker had laboratory studies a year before this visit. The physical exam noted motor strength was 5 out of 5. The dorsi flexors were 5 out of 5 bilaterally. The ankle planter flexors were 5 out of 5 bilaterally. The knee extensors and flexors were 5 out of 5 bilaterally. The sensory exam noted decreased sensation over the medial foot on both sides. There was facet provocation and tenderness. The straight leg raises were positive bilaterally. The treatment plan included laboratory studies of serum AST, ALT and a renal panel for liver and kidney function.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Labs Serum AST (aspartate aminotransferase test) and ALT (alanine aminotransferase test): Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation National Institutes of Health.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines History and physical assessment Page(s): 5-6.

**Decision rationale:** Pursuant to the Chronic Pain Medical Treatment Guidelines, labs serum AST and ALT are not medically necessary. Thorough history taking is there 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 diagnosis is lumbar radiculopathy. The date of injury is January 10, 2010. The injured worker's current medications include Zoloft, Ambien CR, Nabumetone, Percocet, Robaxin and Aleve. Documentation according to a May 6, 2015 progress note states labs were drawn June 2 of 2014 and were all normal. The treating provider is requesting additional liver function tests (AST and ALT). There is no history of liver disease documented in the medical record. There is no history of renal disease documented in the medical record. There is no specificity indicating what medication is being tested for liver dysfunction. Consequently, absent clinical documentation with a clinical indication and rationale with medication specificity and normal labs June 2, 2014, labs serum AST and ALT are not medically necessary.

**Renal Panel for monitoring of Liver & Kidney function: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation National Institutes of Health.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines History and physical assessment Page(s): 5-6.

**Decision rationale:** Pursuant to the Chronic Pain Medical Treatment Guidelines, renal panel for monitoring liver and kidney function is not medically necessary. Thorough history taking is there 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

diagnosis is lumbar radiculopathy. The date of injury is January 10, 2010. The injured worker's current medications include Zoloft, Ambien CR, Nabumetone, Percocet, Robaxin and Aleve. Documentation according to a May 6, 2015 progress note states labs were drawn June 2 of 2014 and were all normal. The treating provider is requesting additional liver function tests (AST and ALT). There is no history of liver disease documented in the medical record. There is no history of renal disease documented in the medical record. There is no specificity indicating what medication is being tested for liver dysfunction. Consequently, absent clinical documentation with a clinical indication and rationale with medication specificity and normal labs June 2, 2014, renal panel for monitoring liver and kidney function is not medically necessary.