MAXIMUS Federal Services

Case Number:	CM15-0073323		
Date Assigned:	04/23/2015	Date of Injury:	05/28/2011
Decision Date:	05/28/2015	UR Denial Date:	04/06/2015
Priority:	Standard	Application Received:	04/16/2015

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: Maryland, Texas, Virginia
Certification(s)/Specialty: Internal Medicine, Allergy and Immunology, Rheumatology

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 39 year old, male who sustained a work related injury on 5/28/11. There are no blood sugar or diabetes related diagnoses. The treatment has included the medication Metformin. In the PR-2 dated 3/19/15, the injured worker had fasting blood sugars that ranged from 200-300 while an inpatient in the hospital. The treatment plan is suggestions to provide the injured worker with a blood glucose meter, lancets and test strips.

IMR ISSUES, DECISIONS AND RATIONALES

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

Glucometer #1: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Diabetes, Glucose monitoring.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Glucose monitoring.

Decision rationale: The MTUS is silent on blood glucose monitoring for diabetes, so the ODG guidelines were used. The ODG states that, "Recommend self-monitoring of blood glucose (SMBG) for people with type 1 diabetes as well as for those with type 2 diabetes who use insulin therapy, plus long-term assessment, but not continuous glucose monitoring (CGM) for routine use. Current glucose monitoring strategies can be classified into 2 categories: patient self-monitoring, which would allow patients to change behavior (diet or exercise) or medication dose (most often insulin), or long-term assessment, which allows both the patient and the clinician to evaluate overall glucose control and risk for complications over weeks or months. Although some form of glucose self-monitoring has long been available, current-day forms of self-monitoring include self-monitoring of blood glucose (SMBG) and continuous glucose monitoring (CGM), while long-term assessment is most often by A1C. Accuracy of the current generation of CGM devices is not yet deemed sufficient by the FDA to recommend them for routine use. A1C should be measured at least twice yearly in all patients with DM and at least 4 times yearly in patients not at target. SMBG should be performed by all patients using insulin (minimum of twice daily and ideally at least before any injection of insulin). More frequent SMBG after meals or in the middle of the night may be required for insulin-taking patients with frequent hypoglycemia, patients not at A1C targets, or those with symptoms. Patients not requiring insulin therapy may benefit from SMBG, especially to provide feedback about the effects of their lifestyle and pharmacologic therapy; testing frequency must be personalized." In this case there is no clear establish diagnosis of diabetes. The medical records state that the patient's inpatient blood glucose levels were 200-300, however it is unclear when these levels were taken, if they were fasting and there is no copy of the labs in the records. He is also not on insulin or oral diabetes medications at this time. As such, the request for Glucometer #1 is not medically necessary.

Blood Glucose Strip #100: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Diabetes, Glucose monitoring.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Glucose monitoring.

Decision rationale: The MTUS is silent on blood glucose monitoring for diabetes, so the ODG guidelines were used. The ODG states that, "Recommend self-monitoring of blood glucose (SMBG) for people with type 1 diabetes as well as for those with type 2 diabetes who use insulin therapy, plus long-term assessment, but not continuous glucose monitoring (CGM) for routine use. Current glucose monitoring strategies can be classified into 2 categories: patient self-monitoring, which would allow patients to change behavior (diet or exercise) or medication dose (most often insulin), or long-term assessment, which allows both the patient and the clinician to evaluate overall glucose control and risk for complications over weeks or months. Although some form of glucose self-monitoring has long been available, current-day forms of self-monitoring include self-monitoring of blood glucose (SMBG) and continuous glucose monitoring (CGM), while long-term assessment is most often by A1C. Accuracy of the current

generation of CGM devices is not yet deemed sufficient by the FDA to recommend them for routine use. A1C should be measured at least twice yearly in all patients with DM and at least 4 times yearly in patients not at target. SMBG should be performed by all patients using insulin (minimum of twice daily and ideally at least before any injection of insulin). More frequent SMBG after meals or in the middle of the night may be required for insulin-taking patients with frequent hypoglycemia, patients not at A1C targets, or those with symptoms. Patients not requiring insulin therapy may benefit from SMBG, especially to provide feedback about the effects of their lifestyle and pharmacologic therapy; testing frequency must be personalized." In this case there is no clear establish diagnosis of diabetes. The medical records state that the patient's inpatient blood glucose levels were 200-300, however it is unclear when these levels were taken, if they were fasting and there is no copy of the labs in the records. He is also not on insulin or oral diabetes medications at this time. As such, the request for Blood glucose strip#100 is not medically necessary.

Blood Glucose Lancet #100: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Diabetes, Glucose monitoring.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Gluocse monitoring.

Decision rationale: The MTUS is silent on blood glucose monitoring for diabetes, so the ODG guidelines were used. The ODG states that, “Recommend self-monitoring of blood glucose (SMBG) for people with type 1 diabetes as well as for those with type 2 diabetes who use insulin therapy, plus long-term assessment, but not continuous glucose monitoring (CGM) for routine use. Current glucose monitoring strategies can be classified into 2 categories: patient self- monitoring, which would allow patients to change behavior (diet or exercise) or medication dose (most often insulin), or long-term assessment, which allows both the patient and the clinician to evaluate overall glucose control and risk for complications over weeks or months. Although some form of glucose self-monitoring has long been available, current-day forms of self- monitoring include self-monitoring of blood glucose (SMBG) and continuous glucose monitoring (CGM), while long-term assessment is most often by A1C. Accuracy of the current generation of CGM devices is not yet deemed sufficient by the FDA to recommend them for routine use. A1C should be measured at least twice yearly in all patients with DM and at least 4 times yearly in patients not at target. SMBG should be performed by all patients using insulin (minimum of twice daily and ideally at least before any injection of insulin). More frequent SMBG after meals or in the middle of the night may be required for insulin-taking patients with frequent hypoglycemia, patients not at A1C targets, or those with symptoms. Patients not requiring insulin therapy may benefit from SMBG, especially to provide feedback about the effects of their lifestyle and pharmacologic therapy; testing frequency must be personalized." In this case there is no clear establish diagnosis of diabetes. The medical records state that the patient's inpatient blood glucose levels were 200-300, however it is unclear when these levels were taken, if they were fasting and there is no copy of the labs in the records. He is also not on insulin or oral diabetes medications at this time. As such, the request for Blood glucose lancet #100 is not medically necessary.