

Case Number:	CM13-0040660		
Date Assigned:	12/20/2013	Date of Injury:	12/26/2012
Decision Date:	07/07/2014	UR Denial Date:	10/17/2013
Priority:	Standard	Application Received:	10/29/2013

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. The expert reviewer is Board Certified in Family Practice and is licensed to practice in Texas and Mississippi. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 49 year old female who reported an injury on 12/26/2012 from exposure to soot. The injured worker had a history of difficulty getting air, occasional use of 2 puffs of Ventolin for wheezing while walking with relief within 5 minutes, raspy voice, and inability to take deep breath. Upon examination on 05/08/2013, the injured worker appeared to have symptoms that began on 12/16/2012, following approximately 3 hour exposure to soot (no smoke) at a store. The injured worker received several inhalers, as well as Singular for presumed asthma reactive airway disease. On examination the injured worker also had some element of chronic/variable hoarseness that was possibly due to the initial exposure or possibly related to steroid dysphonia. The injured workers prior Spirometry and her peak flow expiration flow rate on 05/08/2013 all appeared to be within normal limits, while the physical exam revealed no evidence of inspiratory stridor or expiratory obstructive airway disease. The injured worker had diagnoses of status post fire soot exposure 12/26/2012, cough/dyspnea, reported secondary to soot exposure, and chronic snoring. The provider recommended holding all meter-dose inhaled medications except albuterol MDI using an Aero Chamber on an as needed basis. The injured worker was also seen at another medical center on several occasions prior to 05/08/2013 with minimal adventitious findings upon examination of the injured worker's respiratory system on few occasions. The treatment plan was to schedule a full pulmonary function test with pre- and post-bronchodilators, as well as lung diffusion capacity testing and arterial blood gasses, schedule 6-minute walk test to assess functional ability, hold all meter dose inhalers except albuterol MDI using an Aero Chamber on an as needed basis, continue daily peak flow meter assessment with diary, and consider ENT evaluation pending the above. The request for authorization form was not provided within the documentation submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

URGENT PULMONARY CONSULTATION FOR 3 VISITS: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management Page(s): 89-92. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pulmonary, Office Visits.

Decision rationale: The request for urgent pulmonary consultation for 3 visits is not medically necessary. The injured worker had a history of coughing, difficulty getting air, occasional use of 2 puffs of Ventolin for wheezing while walking with relief within 5 minutes, raspy voice, and inability to take deep breath. The California Medical Treatment Utilization Schedule (MTUS)/American College of Occupational and Environmental Medicine (ACOEM) recommend a referral may be appropriate if the practitioner is uncomfortable with the line of inquiry outlined above, with treating a particular cause of delayed recovery (such as substance abuse), or has difficulty obtaining information or agreement to a treatment plan. The Official Disability Guidelines (ODG) note the need for a clinical office visit with a health care provider is individualized based upon a review of the patient concerns, signs and symptoms, clinical stability, and reasonable physician judgment. The determination of necessity for an office visit requires individualized case review and assessment, being ever mindful that the best patient outcomes are achieved with eventual patient independence from the health care system through self care as soon as clinically feasible. The injured worker has chronic snoring and was seen on various occasions with the results of a clear chest with the cough. There is a lack of documentation of a recent, adequate, and complete assessment of the injured worker's respiratory condition demonstrating significant findings which would indicate her need for a pulmonary consultation. Additionally, the injured workers need for 3 visits is not demonstrated within the provided documentation. As such, the request is not medically necessary.