

Case Number:	CM13-0064091		
Date Assigned:	01/03/2014	Date of Injury:	10/27/2011
Decision Date:	05/08/2014	UR Denial Date:	11/20/2013
Priority:	Standard	Application Received:	12/11/2013

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, has a subspecialty in Preventive Medicine, and is licensed to practice in California. 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 patient is a 32-year-old sustained a work injury on October 27, 2011, resulting in chronic neck pain, back pain, knee pain and sleep disturbance. His diagnoses included cervical stenosis, hypertension, lumbar radiculopathy, and knee strain. A recent examination on November 13, 2013 by his chiropractor noted trigger points in the spine, painful range of motion of the cervical spine, positive leg raise on the left, and a positive McMurray's sign of the left knee. He had weakness with pain that was aggravated with walking, standing and bending. On November 14, 2013 the chiropractor ordered acupuncture sessions along with Cardio-Respiratory Diagnostic Testing to measure autonomic nervous system response. In addition a respiratory diagnostic testing was ordered along with a sleep study to measure respiratory function and screen for signs arising from a prior injury.

IMR ISSUES, DECISIONS AND RATIONALES

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

SPIROMETRY TESTING: 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 OFFICIAL DISABILITY GUIDELINES (ODG) PULMONARY GUIDELINES

Decision rationale: Separated into simple spirometry and complete pulmonary function testing. The simple spirometry will measure the forced vital capacity (FVC) and provides a variety of airflow rates such as the forced expiratory volume in one second (FEV1) and the forced expiratory flow between 25-75% of the total exhaled volume (FEF25-75). The complete pulmonary function test (PFT) adds tests of the lung volumes and the diffusing capacity for carbon monoxide (DLCO). Lung volumes can be assessed by traditional methods or by using plethysmography, requiring the use of a body box. The latter test can also test for airflow resistance and conductance. Other tests of pulmonary function useful in asthma include the spirometry before and after the use of a bronchodilator or after the use of a bronchoconstrictor (generally followed by a bronchodilator). The use of a bronchoconstricting agent is termed "bronchoprovocation" and commonly used agents include chemical agents (acetylcholine, methacholine, and putative occupational chemical exposures), physical agents (cold air, dry air), and exercise. Also useful in asthmatics is the use of peak flow meters to determine the presence of asthma, the response to treatment, and exacerbations of asthma. Recommended in asthma. In other lung diseases, it can be used to determine the diagnosis and provide estimates of prognosis. In these diseases, the complete PFT is utilized and, on occasions, incorporates pulmonary exercise stress testing. Recommended for the diagnosis and management of chronic lung diseases. Lastly, it is recommended in the pre-operative evaluation of individuals who may have some degree of pulmonary compromise and require pulmonary resection or in the pre-operative assessment of the pulmonary patient. In this case, there is no mention of COPD (chronic obstructive pulmonary disease), Asthma, Cancer, Cough, lung Disease, etc. There is no documentation of exertional dyspnea, pre-operative evaluation or abnormal clinical exam. Furthermore, the order is placed by a chiropractor who is not trained in cardiopulmonary management. The request for spirometry testing is not medically necessary or appropriate.

PULMONARY FUNCTION TESTING: 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 OFFICIAL DISABILITY GUIDELINES (ODG)
PULMONARY TREATMENT

Decision rationale: Separated into simple spirometry and complete pulmonary function testing. The simple spirometry will measure the forced vital capacity (FVC) and provides a variety of airflow rates such as the forced expiratory volume in one second (FEV1) and the forced expiratory flow between 25-75% of the total exhaled volume (FEF25-75). The complete pulmonary function test (PFT) adds tests of the lung volumes and the diffusing capacity for carbon monoxide (DLCO). Lung volumes can be assessed by traditional methods or by using plethysmography, requiring the use of a body box. The latter test can also test for airflow resistance and conductance. Other tests of pulmonary function useful in asthma include the spirometry before and after the use of a bronchodilator or after the use of a bronchoconstrictor (generally followed by a bronchodilator). The use of a bronchoconstricting agent is termed "bronchoprovocation" and commonly used agents include chemical agents (acetylcholine,

methacholine, and putative occupational chemical exposures), physical agents (cold air, dry air), and exercise. Also useful in asthmatics is the use of peak flow meters to determine the presence of asthma, the response to treatment, and exacerbations of asthma. Recommended in asthma. In other lung diseases, it can be used to determine the diagnosis and provide estimates of prognosis. In these diseases, the complete PFT is utilized and, on occasions, incorporates pulmonary exercise stress testing. Recommended for the diagnosis and management of chronic lung diseases. Lastly, it is recommended in the pre-operative evaluation of individuals who may have some degree of pulmonary compromise and require pulmonary resection or in the pre-operative assessment of the pulmonary patient. In this case, there is no mention of COPD, Asthma, Cancer, Cough, lung Disease, etc. There is no documentation of exertional dyspnea, pre-operative evaluation or abnormal clinical exam. Furthermore, the order is placed by a chiropractor who is not trained in cardiopulmonary management. The request for pulmonary function testing is not medically necessary or appropriate.

STRESS TESTING: 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 OTHER MEDICAL TREATMENT GUIDELINE OR MEDICAL EVIDENCE: AMERICAN HEART ASSOCIATION GUIDELINES FOR EXERCISE TESTING.

Decision rationale: Stress testing is indicated for those with abnormal EKGs (electrocardiograms), myocardial infarction, angina, cardiac risk factors, exertional dyspnea, etc. In this case, there is no mention of heart disease besides hypertension. There is no abnormal cardiac clinical exam. The weakness is associated with musculoskeletal complaints. In addition, the request for a stress test is from a chiropractor. This profession is not trained in cardiac management. The request for stress testing is not medically necessary or appropriate