

Case Number:	CM14-0124083		
Date Assigned:	09/16/2014	Date of Injury:	04/15/2010
Decision Date:	11/18/2014	UR Denial Date:	07/10/2014
Priority:	Standard	Application Received:	08/06/2014

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. The expert reviewer is Board Certified in Occupational 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 applicant is a represented [REDACTED] employee who has filed a claim for chronic low back pain reportedly associated with an industrial injury of April 15, 2010. Thus far, the applicant has been treated with the following: Analgesic medications; earlier lumbar spine surgery; reported diagnosis with pulmonary embolism; anticoagulation with Coumadin; and work restrictions. In a Utilization Review Report dated July 10, 2014, the claims administrator approved a request for two followup visits, partially certified two sessions of oximetry, and partially certified a request for spirometry as two sessions of the same. The applicant's attorney subsequently appealed. In a progress note dated July 17, 2014, the applicant apparently presented with persistent complaints of low back pain, thoracic spine pain, and shortness of breath. The claimant's pulse oximetry was not performed in the clinic. The claimant did have a pulse of 118. The claimant exhibited a normal cardiopulmonary exam. The claimant was also having issues with voice hoarseness. A 20-pound lifting limitation was endorsed. It appears that authorization for oximetry and pulse oximetry were sought. In a pulmonology note dated July 9, 2014, the claimant apparently presented with issues associated with exertional dyspnea, shortness of breath, and inspirophasic chest pain. The claimant was on Xopenex, Ventolin, Coumadin, QVAR, albuterol, Lasix, and potassium. The claimant had a pulse oximetry of 98% on room air with a normal cardiopulmonary exam. The claimant was given a diagnosis of bronchial asthma with a lung nodule and a history of pulmonary embolism status post placement of inferior vena cava filter. The claimant was asked to obtain CT imaging of the chest.

IMR ISSUES, DECISIONS AND RATIONALES

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

OXIMETRY: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation NATIONAL INSTITUTE OF HEALTH NH PUBLIC ACCESS

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Variations in Physician Interpretation of Overnight Pulse Oximetry Monitoring, Ramsey et al, CHEST, September 2007. Other Medical Treatment Guideline or Medical Evidence: <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2734414/>

Decision rationale: No, the request for oximetry is not medically necessary, medically appropriate, or indicated here. The nature of the request was imprecise. It was not clearly stated whether this request represented a one-time request for oximetry in the clinic setting or overnight pulse oximetry. The MTUS does not address the topic. While the review article appearing in CHEST, September 2007, does acknowledge that overnight pulse oximetry is commonly used for hypoxemia evaluation in applicants with COPD and/or sleep-disordered breathing, in this case, however, the applicant is not hypoxemic. The applicant apparently received a finger pulse oximetry measurement in the clinic setting on July 9, 2014, which was 98% on room air. No clear rationale for oximetry/overnight pulse oximetry was proffered by the attending provider. There was no explicit discussion of the reasons for the test in question. Therefore, the request is not medically necessary.

SPIROMETRY: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Medscape, Pulmonary Function Testing

Decision rationale: Conversely, the request for spirometry is medically necessary, medically appropriate, and indicated here. The MTUS does not address the topic. As noted by [REDACTED], spirometry can be employed to establish baseline lung function, evaluate dyspnea, detect pulmonary disease, evaluate respiratory impairment, and monitor effects of therapies used to treat respiratory disease. In this case, the applicant has a known diagnosis of chronic obstructive pulmonary disease, it was stated above. The applicant is developing worsening shortness of breath, it was suggested on at least two occasions, referenced above. Obtaining a pulmonary function testing/spirometry to evaluate the applicant's COPD progression is therefore indicated. Accordingly, the request is medically necessary.