

<b>Case Number:</b>	CM14-0128707		
<b>Date Assigned:</b>	08/18/2014	<b>Date of Injury:</b>	07/03/2007
<b>Decision Date:</b>	09/11/2014	<b>UR Denial Date:</b>	08/01/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/13/2014

### 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 Family 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:

This 52 -year old man sustained a right shoulder injury on 7/3/07. There is no available documentation on the mechanism of injury. He developed Acute Respiratory Distress Syndrome after a rotator cuff surgery on 6/11/08, which resulted in anoxic brain damage and continuing problems with his lungs. The R rotator cuff repair was redone on 10/25/11, and further shoulder surgeries are being contemplated on both shoulders. Current problems include anoxic encephalopathy with cognitive defects, a movement disorder with dystonia and tics, ataxia, left shoulder rotator cuff tear, severe obstructive sleep apnea, dyspnea on exertion and fatigue with activity, depression, anxiety and obsessive compulsive disorder. Medications as of 3/27/14 included Amlodipine, Atenolol, Combivent, Diazepam, Diovan, Hydrochlorothiazide, Percocet, sildenafil, Simvastatin, and Axiron. A request for evaluation with a pulmonologist was made 1/16/14 due to the patient's ongoing problems with breathing. The request was approved in UR, but there apparently was a delay due to the difficulty in finding a pulmonologist who would accept a Workers' Compensation case. Reference is made in the Utilization Review dated 6/16/14 when a visit to a pulmonology clinic for follow-up of dyspnea was made. According to the report, the patient hyperventilated during the exam and became alkalemic and functionally hypocalcemic, which resulted in muscle spasm. At the time his respiratory rate was 40. Testing done during the visit revealed an oxygen saturation of 95% which decreased to 91% with walking, an FVC of 78% expected, and an FEV1 of 85% expected. A request was generated during this visit for a CT of the thorax without contrast in order to better evaluate the patient's pulmonary parenchyma. This request was denied in UR on 8/1/14 on the grounds that previous chest x-ray, blood gas, carbon monoxide diffusion and 6-minute walking test results had not been reviewed or discussed, and that the contribution of the patient's anxiety disorder to his respiratory symptoms had not been taken into account.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**CT thorax without contrast:** Overturned

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints. Decision based on Non-MTUS Citation ODG Pulmonary Chapter.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pulmonary Chapter, CT American College of Radiology Appropriateness Criteria, Thoracic section, Chronic Dyspnea of Suspected Pulmonary origin.

**Decision rationale:** Per the ODG reference above, "High-resolution CT imaging is recommended in the setting of presumed interstitial lung disease or bronchiectasis. The ACR Appropriateness Criteria cited above states that in the setting of chronic dyspnea, "The most appropriate imaging study is a thin-section high-resolution chest CT with prone imaging when appropriate. In patients with obstructive or mixed PFTs, the inclusion of expiratory imaging is important to evaluate air trapping and possible tracheobronchomalacia. The appropriateness rating is 9, which is the highest possible. Plain chest X-ray is also given a rating of 9, but with a caveat that a negative chest x-ray does not exclude the presence of diffuse disease." This patient has dyspnea since 2008, which would definitely make it chronic. Certainly there may be a contribution from his anxiety disorder, and the results of previous testing might or might not be helpful. However, the fact remains that he has chronic dyspnea with abnormal pulmonary function testing and oxygen desaturation with exertion. A high-resolution thoracic CT scan would be medically advisable in this situation to rule in or out conditions that would require a different treatment approach than those being used now. Based on the evidence-based criteria listed and the clinical findings in this case, a CT of the thorax without contrast is medically necessary.