

Case Number:	CM14-0040254		
Date Assigned:	06/27/2014	Date of Injury:	12/17/2011
Decision Date:	08/22/2014	UR Denial Date:	03/21/2014
Priority:	Standard	Application Received:	04/07/2014

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:

This case involves a 55 year old male who sustained an injury on 12/17/2011 to his shoulder and back while pulling a pallet of dog food out of a truck. The injured worker also reported an injury to an unknown body part when cans fell onto him. He was examined on 01/09/2014 which was noted the injured worker attended physical therapy without relief of symptoms. He is currently taking Ibuprofen. His past history was consistent with injury to his neck, right shoulder acromioplasty, distal clavicle excision, and cervical spine. The patient had no history of alcohol or tobacco use and had a healthy appearance. His lungs were clear upon examination. On the 01/10/2014 examination the injured worker was one day post left arthroscopic acromioplasty and distal clavicle excision. He complained of increased pain and his shoulder felt unstable. He was using his shoulder sling. A chest x-ray dated 01/06/2014 was unremarkable however; the patient was a former smoker smoking 1 pack per day. On 02/21/2014, the doctor recommended post-operative physical therapy. During his follow-up visits there were no reported problems with his pulmonary systems.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective request (DOS: 1/9/14) for outpatient chest x-ray for preoperative clearance:
Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation National Guideline Clearinghouse, ACR

Appropriateness Criteria: A routine admission and preoperative chest radiography, American College of Radiology, Mohammed TL, Kirsch J, Amorosa JK, et al.

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

Decision rationale: The history and documentation do not objectively support the request for an outpatient pre-operative chest x-ray for medical clearance on 01/09/2014. The Official Disability Guidelines (ODG) state chest radiography, with posteroanterior (PA) and lateral views should be the initial imaging test in patients without known or suspected thoracic metastatic disease. If chest radiography demonstrates obvious multiple pulmonary nodules, further imaging beyond follow-up chest radiography may not be indicated. However, unless precise quantification of disease is required in the preoperative evaluation for metastasectomy or the assessment of response to systemic radiation therapy or chemotherapy is needed. Patients with higher probability of pulmonary metastatic disease should be screened more frequently or with a more sensitive imaging modality such as CT. In addition, x-rays are recommended if acute cardiopulmonary findings by history/physical or chronic cardiopulmonary disease are identified in the elderly (> 65). Routine chest radiographs are not recommended in asymptomatic patients with unremarkable history and physical examinations. A chest x-ray is typically the first imaging test used to help diagnose symptoms such as shortness of breath, a bad or persistent cough, chest pain or injury and fever. In individuals with suspected lower respiratory tract infection, it is not recommended unless the following are present heart rate > 100 beats per minute (BPM); respiratory rate > 24 BPM; temperature > 38.0C; and physical findings suggesting consolidation such as egophany or fremitus. As such, this request is not medically necessary.