

Case Number:	CM14-0046747		
Date Assigned:	07/02/2014	Date of Injury:	11/01/2011
Decision Date:	09/18/2014	UR Denial Date:	03/28/2014
Priority:	Standard	Application Received:	04/14/2014

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 Internal 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 injured worker is a 45 year old woman who suffered an industrial injury on November 01, 2011. The mechanism of injury is not described. The diagnoses are listed osteomyelitis of jaw, post traumatic stress disorder, chronic pain, malaise and anxiety as well as depression. She has a history of hypertension as well. Evaluation of sleep disorder breathing was done by [REDACTED] and found to have an Apnea-Hypopnea Index (AHI) and respiratory disturbance index (RDI) that were normal. There was no evidence of sleep apnea at that time (evaluation done by Pulmonary physician October through December 2013). She has no reported difficulty breathing. There are no physical examination findings to suggest cardiac or pulmonary disease. An echocardiogram was reported to be normal with the exception of moderate tricuspid regurgitation. Further, she had a six minute walk screening test, also done by the Pulmonary and Sleep physician which was normal and her saturations registered above 98% at all times. She does not have chest pain, edema, dyspnea, cough, expectoration or hemoptysis. There is no report of smoking heavily or smoking related lung disease. The current request is for a sleep study and cardiorespiratory testing.

IMR ISSUES, DECISIONS AND RATIONALES

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

Pulmonary Function/Stress Testing: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines Pulmonary Chapter.

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: Harrison's Principles of Internal Medicine, 18th Ed, McGraw Hill.

Decision rationale: The injured worker does not have any signs or symptoms of cardiac or pulmonary disease that are documented in the medical record. Typical symptoms would include dyspnea, cough, expectoration. History would typically include older age and smoking or occupational exposures. And examination would include abnormal breath sounds with wheezing or crackles. None of these is documented in the medical record. Further, the patient had a six minute walk test with normal oxygen saturations. Therefore, as of December 2013, she had no evidence of pulmonary or cardiac mediated hypoxemia. Therefore, request for pulmonary function testing or stress test is not medically necessary.

Sleep Disordered Breathing Study: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines Pulmonary Chapter.

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: Harrison's Principles of Internal Medicine, 18th Ed, McGraw Hill. OSA Evaluation and Management Guidelines: American Academy of Sleep Medicine. Available online: http://www.aasmnet.org/Resources/clinicalguidelines/OSA_Adults.pdf Accessed 9/15/2014.

Decision rationale: The injured worker has a history of obesity but the medical records do not indicate snoring, morning headaches, excessive daytime sleepiness, enlarged neck diameter on examination or a positive screening scale such as an Epworth Sleepiness Scale. Further, the patient has symptoms and signs of Posttraumatic stress, Fatigue and Anxiety. She has several other reasons for malaise and fatigue. She has had a one-night sleep study by [REDACTED] in October 2013, which showed no evidence of sleep apnea. Therefore, additional studies for sleep apnea are not supported based on the medical record.