

Case Number:	CM13-0062332		
Date Assigned:	12/13/2013	Date of Injury:	04/12/2012
Decision Date:	03/11/2015	UR Denial Date:	11/19/2013
Priority:	Standard	Application Received:	12/06/2013

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
 State(s) of Licensure: District of Columbia, Virginia
 Certification(s)/Specialty: Internal Medicine

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 42 year old male sustained a work related injury on 04/12/2012. According to a progress report dated 10/02/2013, the injured worker complained of intermittent dull, achy, sharp left wrist pain and numbness and tingling associated with repetitive movement, repetitive twisting, repetitive grabbing/grasping, repetitive gripping and repetitive squeezing. Objective findings included left wrist extension 55/60, flexion 60/60, radial deviation 15/20 and ulnar deviation 25/30. Phalen's and Tinel's were positive. Diagnoses included dorsal intercalated segment instability, left wrist pain and left wrist sprain/strain. According to medical records treatments have included physiotherapy, chiropractic therapy, massage, moist heat, electrical stimulation, traction and supportive care. Phalen's and Tinel's were positive. There was no mention in the medical records submitted for review a history of pulmonary compromise or respiratory insufficiencies. According to a Medical Examination and Orthopaedic Medical Consultation dated 07/23/2013, the injured worker denied any history of stroke, seizure, arthritis, heart disease, high blood pressure, bronchial asthma, ulcers, psychiatric, hepatitis, infectious disease, hypertension, diabetes mellitus, lung disease, epilepsy tuberculosis, collagen disease or cancer or any other serious illness. On 11/19/2013, Utilization Review non-certified Urgent Sleep Disordered Breathing Respiratory Study Including Overnight Pulse Oximetry and Nasal Function Studies 95806, 94762, 92512 and Urgent Spirometry and Pulmonary Function and Stress Testing 94010, 94620, 94621. According to the Utilization Review physician, there was no mention in the medical records regarding pulmonary status or compromise to function that necessitates special study. There was insufficient information provided by the attending health

care provider to associate or establish the medical necessity or rationale for the request. Guidelines cited for this review included Official Disability Guidelines, Pulmonary Function Testing and Polysomnography. The decision was appealed for an Independent Medical Review.

IMR ISSUES, DECISIONS AND RATIONALES

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

SLEEP DISORDERED BREATHING RESPIRATORY STUDY INCLUDING OVERNIGHT PULSE OXIMETRY AND NASAL FUNCTION STUDIES: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation polysomnography

Decision rationale: ODG addresses polysomnography but not CPAP titration. Per ODG, the criteria for these tests include the following: 1) excessive daytime somnolence; 2) cataplexy brought on by excitement or emotion virtually unique to narcolepsy; 3) morning headache when other causes have been ruled out; 4) intellectual deterioration without suspicion of organic dementia; 5) personality change not secondary to medications, cerebral mass or known psychiatric problems; 7) insomnia complaints for at least 6 months at least four nights a week unresponsive to behavior intervention and sedative sleep-promoting medications and psychiatric etiology has been excluded. A sleep study for the sole complaint of snoring without 1 of the above symptoms is not recommended. This patient had no issues with respiratory compromise. Further testing would not be indicated at this time.

SPIROMETRY AND PULMONARY FUNCTION AND STRESS TESTING: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG PULMONARY

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation pulmonary chapter

Decision rationale: Per ODG, pulmonary function testing (PFT) is recommended as follows: separated into simple spirometry and complete pulmonary function testing. The simple spirometry will measure the forced vital capacity and provide a variety of airflow rates such as forced expiratory volume in one second and the forced expiratory flow between 25-75% of the total exhale volume. The complete PFT adds tests of the lung volumes and the diffusing lung capacity for carbon monoxide. Lung volumes can be assessed by traditional methods or by using plethysmography, requiring 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 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, physical agents and

exercise(Birnbaum 2007). 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. PFT is utilized and, on occasions, incorporates pulmonary exercise stress testing. Recommended for the diagnosis and management of chronic lung diseases(NHLBI/WHO 2007). 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 (Colice 2007, Brunelli 2007).This patient had no respiratory issues and this testing would not be warranted at this time.