

Case Number:	CM14-0192716		
Date Assigned:	11/26/2014	Date of Injury:	01/12/1996
Decision Date:	02/25/2015	UR Denial Date:	11/06/2014
Priority:	Standard	Application Received:	11/18/2014

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. 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: California, Indiana, New York
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:

The injured worker (IW) is a 53-year-old man with a date of injury of January 12, 1996. The mechanism of injury reportedly occurred from prolonged, long exposure to Beryllium. The injured worker's working diagnoses are osteopenia/bone disorder; shortness of breath; morbid obesity; depression; and Beryllium exposure. Pursuant to the pulmonary progress note dated October 22, 2014, the IW presents for pulmonary follow-up. There is no physical examination documented. Vital signs are documented as pulse: 80, blood pressure 132/88, respirations: 20, height: 6"2", and weight 322 lbs. The IW underwent pulmonary function tests (PFTs) on July 29, 2014. At that time, the injured worker's oxygen saturation was 96% on room air. The treating physician reports the IW is worsening and PFTs are worse with restriction and severe obstruction/asthma. The IW is on low dose Prednisone and Albuterol Sulfate to use with nebulizer. The IW was instructed to follow-up in 1 month. The current request is for HRCT chest.

IMR ISSUES, DECISIONS AND RATIONALES

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

HRCT (High-resolution computed tomography) Chest without contrast: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pulmonary, CT (computed tomography)

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

Decision rationale: Pursuant to the Official Disability Guidelines, high-resolution computed tomography chest without contrast is not necessary. Computed tomography is recommended and is the preferred method of establishing the diagnosis of bronchiectasis. CT imaging is recommended in the evaluation of individuals with presumed interstitial lung disease or bronchiectasis. CT is the main imaging technique for preoperative staging and post therapeutic evaluation abroad for bronchogenic carcinoma; for patients were either unknown or suspected lung cancer or eligible for treatment. In this case, the injured worker's working diagnoses are obesity morbid; depression; shortness of breath; and beryllium exposure. The assessment in an October 22, 2014 progress note states the PFTs (from an early function test) are worse with restriction and severe obstruction/asthma. The injured worker takes inhalation nebulizer treatments. The documentation contains normal vital signs with a respiratory rate of 20 or a physical examination with objective findings. There was no pulse oximetry. (Last pulse ox was 96% in July 2014). There is no documentation of ongoing shortness of breath or shortness of breath on exertion. The documentation does not supply the clinical rationale (by the requesting physician) for the high resolution CT imaging. Consequently, absent clinical documentation and the clinical rationale for performing the high resolution computed tomography of the chest without contrast, the high resolution computed tomography of the chest without contrast is not medically necessary.