

Case Number:	CM15-0105636		
Date Assigned:	06/10/2015	Date of Injury:	07/13/2009
Decision Date:	07/14/2015	UR Denial Date:	05/11/2015
Priority:	Standard	Application Received:	06/01/2015

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: Arizona, Michigan

Certification(s)/Specialty: Preventive Medicine, Occupational 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 was a 59 year old female, who sustained an industrial injury, July 13, 2009. The injured worker previously received the following treatments laboratory studies completed on April 15, 2015 noted an elevated HbA1C, pulmonary function testing completed on April 22, 2015, EMG/NCS (electrodiagnostic studies and nerve conduction studies) of the upper and lower extremities, cervical spine MRI, right shoulder arthroscopic surgery and arthroscopic surgery of the left knee. The injured worker was diagnosed with back pain, degenerative disc changes and facet joint changes of the cervical spine, chemical exposure, diabetes mellitus, emotional stressors, depression, shortness of breath, asthma and tri-compartment osteoarthritis changes involving the medial compartment of the left knee, moderate osteoarthritic changes seen involving the lateral compartment of the patellofemoral joint and bilateral carpal tunnel syndrome. According to progress note of May 7, 2015, the injured workers chief complaint was no complains. The treating physician reviewed laboratory studies with the injured worker. The treatment plan included EKG (Electrocardiography), urinalysis, venipuncture services for HbA1C, pulmonary function test, lung volume, bronchodilation and NVC (nerve conduction studies).

IMR ISSUES, DECISIONS AND RATIONALES

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

Electrocardiogram (ECG) Qty:1: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation JOHN R. McCONAGHY, MD, CPE, and RUPAL S. OZA, MD, MPH, The Ohio State University, Columbus, Ohio Am Fam Physician. 2013 Feb 1; 87(3):177-182.

Decision rationale: The MTUS/ ACOEM and ODG did not address the use of EKG in the injured worker with chest pain and therefore other guidelines were consulted. Per the AFP journal, "approximately 1 percent of primary care office visits are for chest pain, and 1.5 percent of these patients will have unstable angina or acute myocardial infarction. The initial goal in patients presenting with chest pain is to determine if the patient needs to be referred for further testing to rule in or out acute coronary syndrome and myocardial infarction. The physician should consider patient characteristics and risk factors to help determine initial risk. Twelve-lead electrocardiography is typically the test of choice when looking for ST segment changes, new-onset left bundle branch block, presence of Q waves, and new-onset T wave inversions. For persons in whom the suspicion for ischemia is lower, other diagnoses to consider include chest wall pain/costochondritis (localized pain reproducible by palpation), gastroesophageal reflux disease (burning retrosternal pain, acid regurgitation, and a sour or bitter taste in the mouth), and panic disorder/anxiety state. Other less common but important diagnostic considerations include pneumonia (fever, egophony, and dullness to percussion), heart failure, pulmonary embolism (consider using the Wells criteria), acute pericarditis, and acute thoracic aortic dissection (acute chest or back pain with a pulse differential in the upper extremities). Persons with a higher likelihood of acute coronary syndrome should be referred to the emergency department or hospital." A review of the injured workers medical records that are available to me reveal a diagnosis of chest pain, however no details were given for the rationale for ordering an EKG as there are other differentials that could cause chest pain and without this information medical necessity is not medically necessary.

Urinalysis Qty:1: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation JEFF A. SIMERVILLE, M.D., WILLIAM C. MAXTED, M.D., and JOHN J. PAHIRA, M.D., Georgetown University School of Medicine, Washington, D.C Am Fam Physician. 2005 Mar 15;71(6):1153-1162.

Decision rationale: The MTUS / ACOEM and ODG did not sufficiently address the use of urinalysis in the injured worker, therefore other guidelines were consulted. Per the American Family Practice Journal, "Urinalysis is invaluable in the diagnosis of urologic conditions such as calculi, urinary tract infection (UTI), and malignancy. It also can alert the physician to the

presence of systemic disease affecting the kidneys. Urinalysis is not recommended as a routine screening tool except in women who may be pregnant." A review of the injured workers medical records did not reveal a clear rationale for ordering a urinalysis in the injured worker and without this information medical necessity is not medically necessary.

Venipuncture (labs ordered: HbA1C and pulmonary function tests) Qty:1: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Diabetes (Type 1, 2, and Gestational) / Glucose monitoring. Pulmonary (Acute & Chronic) / Pulmonary Function Testing.

Decision rationale: The MTUS / ACOEM did not address the use of HbA1C and Pulmonary function tests in the injured worker, therefore other guidelines were consulted. Per the ODG, A1C should be measured at least twice yearly in all patients with DM and at least 4 times yearly in patients not at target. SMBG should be performed by all patients using insulin (minimum of twice daily and ideally at least before any injection of insulin). More frequent SMBG after meals or in the middle of the night may be required for insulin-taking patients with frequent hypoglycemia, patients not at A1C targets, or those with symptoms. Per the ODG, PFT's are "recommended as indicated. Separated into simple spirometry and complete pulmonary function testing. The simple spirometry will measure the forced vital capacity (FVC) and provides a variety of airflow rates such as the forced expiratory volume in one second (FEV1) and the forced expiratory flow between 25-75% of the total exhaled volume (FEF25-75). The complete pulmonary function test (PFT) adds tests of the lung volumes and the diffusing capacity for carbon monoxide (DLCO). Lung volumes can be assessed by traditional methods or by using plethysmography, requiring the 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 the 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 (acetylcholine, methacholine, and putative occupational chemical exposures), physical agents (cold air, dry air), and exercise. (Birnbaum, 2007) Also useful in asthmatics is the use of peak flow meters to determine the presence of asthma, the response to treatment, and exacerbations of asthma. Recommended in asthma. (NHLBI, 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. 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". Unfortunately, a review of the injured workers medical records that are available did not reveal a rationale or therapeutic goal for ordering these tests at this time other than a diagnosis and without this information the request is not medically necessary.

Lung volume Qty: 1: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pulmonary (Acute & Chronic) / Pulmonary Function Testing.

Decision rationale: The MTUS / ACOEM did not address the use of Pulmonary Function Tests in the injured worker, therefore other guidelines were consulted. Per the ODG, PFT's are "recommended as indicated. Separated into simple spirometry and complete pulmonary function testing. The simple spirometry will measure the forced vital capacity (FVC) and provides a variety of airflow rates such as the forced expiratory volume in one second (FEV1) and the forced expiratory flow between 25-75% of the total exhaled volume (FEF25-75). The complete pulmonary function test (PFT) adds tests of the lung volumes and the diffusing capacity for carbon monoxide (DLCO). Lung volumes can be assessed by traditional methods or by using plethysmography, requiring the 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 the 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 (acetylcholine, methacholine, and putative occupational chemical exposures), physical agents (cold air, dry air), and exercise. (Birnbaum, 2007) Also useful in asthmatics is the use of peak flow meters to determine the presence of asthma, the response to treatment, and exacerbations of asthma. Recommended in asthma. (NHLBI, 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. 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". Unfortunately, a review of the injured workers medical records that are available did not reveal a rationale or therapeutic goal for ordering these tests at this time other than a diagnosis and without this information the request is not medically necessary.

Bronchodilation Qty:1: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pulmonary (Acute & Chronic) / Pulmonary Function Testing.

Decision rationale: The MTUS / ACOEM did not address the use of Pulmonary Function Tests in the injured worker, therefore other guidelines were consulted. Per the ODG, PFT's are

"recommended as indicated. Separated into simple spirometry and complete pulmonary function testing. The simple spirometry will measure the forced vital capacity (FVC) and provides a variety of airflow rates such as the forced expiratory volume in one second (FEV1) and the forced expiratory flow between 25-75% of the total exhaled volume (FEF25-75). The complete pulmonary function test (PFT) adds tests of the lung volumes and the diffusing capacity for carbon monoxide (DLCO). Lung volumes can be assessed by traditional methods or by using plethysmography, requiring the 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 the 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 (acetylcholine, methacholine, and putative occupational chemical exposures), physical agents (cold air, dry air), and exercise. (Birnbaum, 2007) Also useful in asthmatics is the use of peak flow meters to determine the presence of asthma, the response to treatment, and exacerbations of asthma. Recommended in asthma. (NHLBI, 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. 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". Unfortunately, a review of the injured workers medical records that are available did not reveal a rationale or therapeutic goal for ordering these tests at this time other than a diagnosis and without this information the request is not medically necessary.

NCV (body part unspecified) Qty:1: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back - Lumbar & Thoracic (Acute & Chronic) / Electrodiagnostic Studies, (EMG) Electromyography, Nerve Conduction Studies (NCS).

Decision rationale: Per the MTUS, EMG may be useful to identify subtle, focal neurologic dysfunction in patients with low back symptoms lasting more than 3-4 weeks. Per the ODG, EMG's are not necessary if radiculopathy is already clinically obvious. NCS are not recommended. There is minimal justification for performing nerve conduction studies when a patient is presumed to have symptoms on the basis of radiculopathy. EMG/nerve conduction studies (NCS) often have low combined sensitivity and specificity in confirming root injury, and there is limited evidence to support the use of often uncomfortable and costly EMG/NCS. Unfortunately, a review of the injured workers medical records that are available did not reveal a rationale or therapeutic goal for ordering these tests at this time and without this information the request is not medically necessary.