

<b>Case Number:</b>	CM15-0184712		
<b>Date Assigned:</b>	09/25/2015	<b>Date of Injury:</b>	07/15/2010
<b>Decision Date:</b>	11/06/2015	<b>UR Denial Date:</b>	08/20/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/21/2015

### 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: Iowa, Illinois, California

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine, Public Health & General Preventive 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 is a 50 year old male, who sustained an industrial injury on July 15, 2010. Medical records indicate that the injured worker is undergoing treatment for lumbar spondylosis without myelopathy, lumbar discogenic pain, lumbar disc desiccation and bulging, cervical disc injury, right shoulder pain, left knee pain, gastritis and duodenitis. The injured worker was noted to be permanent and stationary. The injured workers current work status was not indicated. The internal medicine report (7-15-15) states that the injured worker noted an improvement in swallowing and an improvement in abdominal pain. The injured worker also noted internal hemorrhoids, blood in the stool, acid reflux, diarrhea and occasional constipation. Physical examination revealed the chest to be clear to auscultation with no rales or wheezes appreciated. The abdomen was soft with normal bowel sounds. There was epigastric tenderness (1+) noted. No guarding or rebound tenderness was noted. Treatment and evaluation to date has included medications, physical therapy, right shoulder surgery (2014) and a left shoulder arthroscopy (2011). Current medications include Dexilant, Gaviscon, MiraLax, Colace, Benzyl, Cymbalta and Voltaren gel. The request for authorization dated 7-15-15 includes a request for a repeat chest x-ray. The Utilization Review documentation dated 8-20-15 non-certified the request for a repeat chest x-ray.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Repeat chest X-ray:** 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 Uptodate.com, conventional chest radiography.

**Decision rationale:** MTUS and ODG are silent in reference to chest x-rays. Uptodate.com states: "Pattern recognition on a conventional chest radiograph is an important first step in the evaluation of patients with diffuse lung disease, although a multitude of diseases can produce the same pattern. (See 'Critique of pattern use' above.) A graphic description is preferable to use of histologic terminology. (See 'Classification' above.) The main radiological patterns used to describe diffuse lung disease are as follows: Nodular (including micronodular and miliary), reticular (fine or ground glass, medium or irregular, coarse or honeycomb), linear (interlobular septal or Kerley lines), combined reticular and nodular, destructive, alveolar, bronchial, and vascular. (See 'Basic patterns' above.) Additional aspects of lung disease that may be characterized by conventional chest radiography are the lung volumes, disease distribution, and associated findings. (See 'Lung volumes' above and 'Disease distribution' above and 'Associated findings' above.) HRCT (thin-section CT) is a very helpful tool to supplement the information from conventional chest radiography. It can refine the differential diagnostic considerations and has improved sensitivity and specificity over conventional chest radiography, particularly in complex cases. In some situations, such as in idiopathic pulmonary fibrosis, HRCT can be definitive and obviate the need for a biopsy. However, in a majority of cases, biopsy may be needed for a definitive diagnosis, particularly if treatment depends on a specific diagnosis. (See 'High resolution computed tomography of the lungs'.)" The medical documentation provided does not indicate any objective cardiopulmonary findings or subjective complaints that would warrant a chest x-ray as outlined in the above guidelines. As such, the request for repeat chest X-ray is not medically necessary at this time.