

Case Number:	CM14-0138329		
Date Assigned:	09/05/2014	Date of Injury:	04/18/2001
Decision Date:	09/30/2014	UR Denial Date:	07/29/2014
Priority:	Standard	Application Received:	08/26/2014

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 Family Medicine, and is licensed to practice in North Carolina. 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 patient is a 52-year-old with a reported date of injury of 04/18/2001. The patient has the diagnoses of asthma, coronary artery disease, neck surgery, back pain, knee surgery, hypertension, cardiac arrhythmia, biceps tendon repair, paroxysmal SVT, spinal fusion and shoulder surgery. The patient presented to the emergency room on 06/05/2014 of shortness of breath, cough and wheezing. Vital signs showed a pulse oximetry value of 97% on room air with a pulse of 101 and a respiratory rate of 30. Physical exam noted no accessory muscle usage with tachypnea and wheezing. The chest x-ray was clear. Blood work showed elevated serum glucose of 171, normal cardiac enzymes and a normal white blood cell count. Peak flow was measured at 450/700 after 3 nebulizer treatments. The patient was admitted because he still had audible expiratory wheezing and he was intoxicated making the emergency room physician question the patient's ability to be complaint with an outpatient regimen.

IMR ISSUES, DECISIONS AND RATIONALES

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

2 Day Inpatient Hospital Retrospective 6/5/2014-06/06/2014: 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: UpToDate adult asthma exacerbation protocol.

Decision rationale: The California MTUS and the ACOEM do not specifically address the requested service, so alternate guidelines were used. The UpToDate clinical acute adult asthma exacerbation assessment was referenced which is peer-reviewed process with literature review current through August 2014. Clinical danger signs are deemed to be use of accessory muscles of respiration, fragmented speech, inability to lay supine, profound diaphoresis, agitation, severe symptoms that fail to improve with initial emergency treatment, inability to maintain respiratory effort, cyanosis and depressed mental status. Assessment should include peak flow rate. A peak flow rate of <200 l/minute indicates severe obstruction. Severe hypoxemia is indicate either by arterial blood gas or by oxygen saturation, 95% on high flow oxygen. The pulmonary index score is based on respiratory rate, degree of wheezing, inspiration to expiratory ratio, accessory muscle use and oxygen saturation. A PIS of greater than or equals to 12 indicates a severe attack. In the case of this patient a PIS cannot be calculated due to no notation of the inspiration to expiration ratio. However based on the other parameters that are documented, this patient would have a PIS of no more than 6. This does not even qualify the patient as moderate. The reason for admission seems not to be directly related to the patient's asthma exacerbation but more to due with the patient's intoxication and inability to be complaint with an outpatient regimen. The guidelines do recommend admission when there is a question of compliance but this is for severe exacerbation that has responded to emergency treatment. In this case criteria has not been met to classify this patient as even moderate exacerbation. The only pulmonary notation the patient still had audible expiratory wheezing but all other PIS factors were normal. For these reasons criteria for admission have not been met and the request is not medically necessary.