

<b>Case Number:</b>	CM14-0153880		
<b>Date Assigned:</b>	10/06/2014	<b>Date of Injury:</b>	07/12/2013
<b>Decision Date:</b>	11/05/2014	<b>UR Denial Date:</b>	09/11/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/22/2014

### 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 Physical Medicine & Rehabilitation and Pain Medicine and is licensed to practice in Texas and Ohio. 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 injured worker is a 45-year-old male who reported an injury on 07/12/2013 due to getting his leg pinned between bumpers of some cars. Diagnosis was deep vein thrombosis of the right lower limb with pulmonary embolism. The injured worker is status post right knee surgery on 01/07/2014. The injured worker developed a deep vein thrombosis on the same leg after surgery, and developed a pulmonary embolism. The injured worker was placed on Coumadin after initial treatment with Lovenox. The prothrombin time was monitored regularly by the primary care physician. The injured worker did not complain of shortness of breath, and stated that he felt fairly well. The injured worker also denied having a cough. Surgeries were left lower shoulder surgery in 2010, and right shoulder surgery in 2010 with no apparent problems following the surgeries. There was no family history of blood clots. Examination of the neck revealed that it was supple, bilateral carotids were well felt, no bruits were noted, and there was no thyromegaly. Examination of the chest revealed equally with normal respiration. There was no thoracic cage tenderness or chest wall deformity. The lungs were clear to percussion and auscultation. Heart sounds were normal. There were no gallops or murmurs heard. Examination of the extremities revealed tenderness over the right popliteal and left calf area. Homan's sign was positive on the left side. Minimal swelling was noted over the left lower limb. Chest x-ray was normal and unremarkable. Lab work revealed white count was mildly elevated, hemoglobin and hematocrit were normal, and platelet count was normal. There was normal differential count. It was reported that the injured worker was to be switched to Xarelto and discontinue the Coumadin. Treatment plan was to do a workup for the injured worker for thrombophilia. The provider reported that he doubted it would be positive findings on workup for thrombophilia. The rationale and Request for Authorization were not submitted.

## IMR ISSUES, DECISIONS AND RATIONALES

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

### **Split night sleep study:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines - TWC Pain Procedure Summary (last updated 7/10/14)

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Polysomnography

**Decision rationale:** decision for split night sleep study is not medically necessary. The Official Disability Guidelines do not address split night sleep study directly, but it does address polysomnography. The Official Disability Guidelines state polysomnography is recommended after at least 6 months of an insomnia complaint (at least 4 nights a week), unresponsive to behavior intervention and sedative/sleep promoting medications, and after psychiatric etiology has been excluded. Criteria for polysomnography are polysomnograms/sleep studies are recommended for the combination of indications listed, excessive daytime somnolence, cataplexy (muscular weakness usually brought on by excitement or emotion, virtually unique to narcolepsy), morning headache (other causes have been ruled out), intellectual deterioration (sudden, without suspicion of organic dementia), personality change (not secondary to medication, cerebral mass, or known psychiatric problems), sleep related breathing disorder or period limb movement disorder is suspected (insomnia complaint for at least 6 months) at least 4 nights of the 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 one of the above mentioned symptoms, is not recommended. The injured worker had no reports or complaints of problems sleeping, insomnia, or snoring. The rationale for ordering a polysomnography for the injured worker was not reported. It was not documented that the injured worker was having cataplexy, narcolepsy, any type of sleep related breathing disorder, or limb movement disorder. Medication for the injured worker was Xarelto. There was no mention if any type of sedative or sleep promoting medication. The clinical information submitted for review does not provide evidence to justify a split night sleep study. Therefore, this request is not medically necessary.

### **CTA (computed tomography angiography):** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Lower limb peripheral arterial disease: diagnosis and management.

<http://www.guideline.gov/content.aspx?id=38409&search=peripheral+arterial+disease>; and the National Clinical Guideline Centre. Lower limb peripheral arterial disease: diagnosis and management. London (UK): National Institute for Health and Clinical Excellence (NICE); 2012 Aug. 28 p. (Clinical guideline; no. 147)

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation <http://my.clevelandclinic.org/services/heart/diagnostics-testing/radiographic-tests/coronary>

**Decision rationale:** The decision for CTA (computed tomography angiography) is not medically necessary. The California Medical Treatment Utilization Schedule, ACOEM, and the Official Disability Guidelines do not address this request. Other resources were referenced, such as the Cleveland Clinic. Coronary CTA examinations are growing in use, coronary angiograms remain the gold standard for detecting coronary artery stenosis, which is a significant narrowing of an artery that could require catheter based intervention (such as placing a coronary artery stent) or surgery (such as placing coronary artery bypass grafts). On the other hand, this new technology has consistently shown the ability to rule out significant narrowing of the major coronary arteries and can noninvasively detect soft plaque, or fatty matter, in their walls that have not yet hardened, but that may lead to future problems without lifestyle changes or medical treatment. The single most important step for patients trying to determine whether they should consider a coronary CTA is consultation with their primary physician. Coronary CTA examinations have tended to help determine a lack of significant narrowing in calcium deposits in the coronary arteries, as well as the presence of fatty deposits. To date, coronary CTA has not been proven as effective as the coronary angiogram in detecting disease in the smaller heart arteries that branch off the major coronary arteries. The injured worker had no reports of chest pain or cough. There were no complaints of shortness of breath on exertion. The lungs were clear to percussion and auscultation, the heart sounds were normal. It was reported that the provider was doing a workup to rule out thrombophilia. There was no clear rationale to support the decision for CTA (computed tomography angiography). The clinical documentation submitted for review does not provide evidence to justify this request. Based on the lack of documentation detailing a clear indication for CTA, this request is not medically necessary.

**Pulmonary function testing:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines - TWC Pulmonary Procedure Summary (last updated 7/29/14)

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

**Decision rationale:** The decision for pulmonary function testing is not medically necessary. The Official Disability Guidelines state that pulmonary function testing is recommended as indicated. Separated into simple spirometry and complete pulmonary function testing. The simple spirometry will measure the force vital capacity (FVC) and provides a variety of air flow rates, such as the forced expiratory volume in 1 second (FEV1) and the forced expiratory flow between 25% to 75% of the total exhaled volume (FEF 25-75). The complete pulmonary function test (PFT) adds test of the lung volumes and the diffusing capacity for carbon monoxide. Lung volumes can be assessed by tradition methods or by using plethysmography, requiring the use of a body box. The latter test can also test for air flow resistance. 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). 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 in management of chronic lung diseases. Lastly, it is recommended in the preoperative evaluation of individuals who may have some degree of pulmonary compromise and require pulmonary resection or in the preoperative assessment of the pulmonary patient. It was not reported that the injured worker had asthma. The injured worker did not report any shortness of breath or a cough. There were no complaints documented of shortness of breath on exertion. The injured worker had a pulmonary embolism. The medical guidelines do not state to have a pulmonary function test if you were diagnosed with a pulmonary embolism. The rationale for requesting a pulmonary function test was not submitted. There is a lack of documentation of evidence to support the decision for pulmonary function testing. Based on the lack of documentation detailing a clear indication for a pulmonary function testing, this request is not medically necessary.

**Echo with bubble contrast:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Zipes: Braunwald's Heart Disease: A Textbook of Cardiovascular Medicine, 7th ed., p. 261.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation  
[http://www.brighamandwomens.org/departments\\_and\\_services/medicine/services/cvc](http://www.brighamandwomens.org/departments_and_services/medicine/services/cvc)

**Decision rationale:** The decision for Echo with bubble contrast is not medically necessary. The California Medical Treatment Utilization Schedule, ACOEM, and the Official Disability Guidelines do not address this request. Brigham and Women's Hospital website was referenced. The Echo with bubble contrast is an ultrasound of the heart that is called an echocardiogram. It is done to get pictures of the heart and the areas around the heart. Better pictures are sometimes seen if a material called contrast is used during the ultrasound. One type of contrast is saline (sterile salt water). When saline is used, it is called a bubble study. During a bubble study, the doctor or nurse will shake the salt water until it forms small bubbles. The bubbles are then injected into the vein through an intravenous line (IV). In a normal heart, the bubbles are filtered by the lungs and are seen only on the right side of the heart. If the bubbles are seen on the left side, it shows that there is an opening between the 2 sides of the heart, which is abnormal. The abnormality can be an atrial septal defect or a ventricle septal defect. The bubble study helps to identify those abnormalities. The rationale for ordering an Echo with bubble contrast was not reported. It was not reported that the provider was looking for atrial septal defect or ventricle septal defect. There is a lack of documentation of objective findings. The injured worker had a normal physical examination with no complaints of chest pain, shortness of breath, no complaints of shortness of breath on exertion. There were no red flags, signs or symptoms reported from the injured worker to warrant an Echo with bubble contrast. The clinical information submitted for review does not provide evidence to justify an Echo with bubble contrast. Therefore, this request is not medically necessary.

## **Carotid Doppler: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Metler: Essentials of Radiology, 2nd ed. Chapter 5 - Cardiovascular System.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation <http://www.nhlbi.nih.gov/health/health-topics/topics/cu/> Other Guidelines

**Decision rationale:** The decision for carotid Doppler is not medically necessary. The California Medical Treatment Utilization Schedule, ACOEM, and the Official Disability Guidelines do not address this request. The National Institute of Health was referenced. Carotid ultrasound is a painless and harmless test that uses high frequency sound waves to create pictures of the insides of the carotid arteries. You have 2 common carotid arteries, one on each side of the neck. They each divide into internal and external carotid arteries. The internal carotid arteries supply oxygen rich blood to your brain. The external carotid arteries supply oxygen rich blood to your face, scalp, and neck. Carotid ultrasound shows whether a waxy substance called plaque has built up in your carotid arteries. The buildup of plaque in the carotid arteries is called carotid artery disease. Over time, plaque can harden or rupture (break open). Hardened plaque narrows the carotid arteries and reduces the flow of oxygen rich blood to the brain. If the plaque ruptures, a blood clot can form on its surface. A clot can mostly or completely block blood flow through a carotid artery, which can cause a stroke. A piece of plaque or a blood clot also can break away from the wall of the carotid artery. The plaque or clot can travel through the blood stream and get stuck in one of the brain's smaller arteries. This can block blood flow in the artery and cause a stroke. The rationale for ordering a carotid Doppler was not submitted with detailed and clear indications reported. Physical examination of the injured worker revealed no bruits were noted, the neck revealed that it was supple, bilateral carotids are well felt. There was no thyromegaly. The injured worker had a deep vein thrombosis of the right lower limb with pulmonary embolism. There is a lack of documentation of objective findings upon the physical examination to support the decision for a carotid Doppler. The clinical information submitted for review does not provide evidence to justify the decision for carotid Doppler. Therefore, this request is not medically necessary.