

<b>Case Number:</b>	CM14-0112372		
<b>Date Assigned:</b>	09/16/2014	<b>Date of Injury:</b>	06/30/2000
<b>Decision Date:</b>	10/27/2014	<b>UR Denial Date:</b>	06/28/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/18/2014

### 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. The expert reviewer is Board Certified in Physical Medicine & Rehabilitation, and is licensed to practice in Illinois. 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 70-year-old male who reported injury on 06/30/2000 due to falling from a chimney onto a rooftop. The injured worker complained of advanced pulmonary disease secondary to his exposure to cresol and weakness, fatigue, increased wheezing, and heaviness in his leg. The injured worker had diagnoses of severe steroid dependent obstructive lung disease secondary to exposure at work, steroid related complications, including osteopenia hyperglycemia, gastro esophageal reflux disease, coronary artery disease, valvular heart disease with episodes of congestive heart failure, discogenic disease of the dorsal spine, and hyperlipidemia. The prior treatments included blood work that consisted of a complete blood count, a Chem panel, brain natriuretic peptide, sputum culture, urinalysis with micro spirometric lung function test. The objective findings dated 07/29/2014 revealed blood pressure 130/80, respirations 18, pulse 80 and temperature 97.3. The lung rales and expiratory wheezing, midline scar secondary to previous coronary artery bypass surgery to the chest, a 2/6 grade systolic murmur, 1 to 2+ edema with arterial oxygen saturation 95% at room air. The medications included Cozaar, Levaquin, Lasix, Advair, Mucinex, Singular, baby aspirin, Proair, prednisone, Flector patch, Spiriva, Norvasc, and Lipitor, and vitamin D. The injured worker was evaluated on 09/17/2014 and it was documented that the injured worker had severe advanced lung disease secondary to exposure to creosol at work. He also had coexisting coronary artery disease and gastro esophageal reflux. The physical examination of the lungs there was slight expiratory wheezing. Physical examination of the heart there was a grade 2/6 systolic murmur. There was 1 to 2+ edema. Pulse oximetry revealed arterial oxygen saturation was 97% at rest on room air. Spirometric lung function testing was FVC actual 2.67, FEV 1 actual was 2.02, FEV 1/FVC actual 76, and FEF 25.75% actual was 1.63. The provider noted differences up to 20% between predicted and measured values are generally considered to be within normal limits. There were

normal expiratory flow rates. Electrocardiogram revealed normal sinus rhythm and no acute ischemic changes. Hemoglobin A1C was 6.9. GI evaluation revealed food regurgitating; he swallowed very shortly thereafter regurgitating back into his mouth. It happens frequently but was not associated with heartburn. He had h/o operation on bleeding ulcer 15 years ago, but no other GI history except for prior symptoms of GERD. The Request for Authorization was not submitted for this review.

## **IMR ISSUES, DECISIONS AND RATIONALES**

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

### **1 hemoglobin A1c test: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation National Guidelines Clearinghouse

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

**Decision rationale:** The request for 1 hemoglobin A1C test is not medically necessary. Official Disability Guidelines (ODG) recommends hemoglobin A1C test for self-monitoring of blood glucose (SMBG) for people with type 1 diabetes as well as for those with type 2 diabetes who use insulin therapy, plus long-term assessment, but not continuous glucose monitoring (CGM) for routine use. Current glucose monitoring strategies can be classified into 2 categories: patient self-monitoring, which would allow patients to change behavior (diet or exercise) or medication dose (most often insulin), or long-term assessment, which allows both the patient and the clinician to evaluate overall glucose control and risk for complications over weeks or months. Although some form of glucose self-monitoring has long been available, current-day forms of self-monitoring include self-monitoring of blood glucose (SMBG) and continuous glucose monitoring (CGM), while long-term assessment is most often by A1C. Accuracy of the current generation of CGM devices is not yet deemed sufficient by the FDA to recommend them for routine use. 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. Patients not requiring insulin therapy may benefit from SMBG, especially to provide feedback about the effects of their lifestyle and pharmacologic therapy; testing frequency must be personalized. Although still early in its development, continuous glucose monitoring (CGM) can be useful for many patients to improve A1C levels and reduce hypoglycemia. Self-monitoring of blood glucose (SMBG) has a small effect on glycemic control in patients with type 2 diabetes who are not using insulin, according to this Cochrane review. Any effect on A1C levels was found to occur only in the first 6 months, during which time the A1C level decreased by 0.26%, and the effect of SMBG was no longer significant at 12 months follow-up, with a decrease in A1C levels of only 0.1%. SMBG has been shown to be an effective tool for people with type 1 diabetes as well as for those with type 2 diabetes who use insulin therapy, because patients use the glucose

levels to adjust insulin doses. The findings question the benefit of SMBG among patients with type 2 diabetes who do not use insulin (or insulin secretagogues such as sulfonylureas) and who are therefore not at increased risk for hypoglycemia. SMBG has its greatest benefit as a safety tool for patients on insulin, to know about and avoid hypoglycemia. When it is used as a therapeutic tool, the evidence is less robust. SMBG doesn't lower blood sugar levels; only lifestyle changes and medicine do, so SMBG only helps when it is coupled to these other interventions. On 09/17/2014, the injured worker had a hemoglobin A1C done that revealed 6.9. The injured worker's glucose level on 06/17/2014 was 7.1; however, the injured worker has a history of prescribed steroid use. Additionally, the provider failed to indicate the rationale for a hemoglobin A1C test and there was 1 done on 09/17/2014. As such, the request for 1 hemoglobin A1C test is not medically necessary.

**1 referral to an endocrinologist:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Standards of medical care in diabetes .V. Diabetes care, Diabetes Care . 2013 Jan; 36 (Suppl 1): Section 16-28

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

**Decision rationale:** The request is not medically necessary. The Official Disability Guidelines (ODG) recommends office visits or referrals determined to be medically necessary. Evaluation and management (E&M) outpatient visits to the offices of medical doctor(s) play a critical role in the proper diagnosis and return to function of an injured worker, and they should be encouraged. The need for a clinical office visit with a health care provider is individualized based upon a review of the patient concerns, signs and symptoms, clinical stability, and reasonable physician judgment. The determination is also based on what medications the patient is taking, since some medicines such as opiates, or medicines such as certain antibiotics, require close monitoring. As patient conditions are extremely varied, a set number of office visits per condition cannot be reasonably established. The determination of necessity for an office visit requires individualized case review and assessment, being ever mindful that the best patient outcomes are achieved with eventual patient independence from the health care system through self-care as soon as clinically feasible. Office visits that exceed the number of office visits listed in the CAA may serve as a "flag" to payors for possible evaluation, however, payors should not automatically deny payment for these if preauthorization has not been obtained. Note: The high quality medical studies required for treatment guidelines such as ODG provides guidance about specific treatments and diagnostic procedures, but not about the recommended number of E&M office visits. Studies have and are being conducted as to the value of "virtual visits" compared with inpatient visits; however the value of patient/doctor interventions has not been questioned. The injured worker has not reported any symptoms of diabetes, although he has had elevated blood glucose levels. The injured worker may not require intervention in the absence of symptoms for suspected steroid induced diabetes. It was documented the injured worker was using prednisone 10 mg. As such, the request for 1 referral to an endocrinologist is not medically necessary.

**Klor-Con 8 mEq #100:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Pinkerman C, Sander P, Breeding JE, Brink D, Curtis R, Hayes R, Ojha A, Pandita D, raikar S, Setterlund L, Sule O, Turner A. Heart failure in

adults. Bloomington (MN): Institute for Clinical Systems Improvement (ICSI); 2013 July page 94.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Drugs.com

**Decision rationale:** The request for Klor-Con 8 mEq # 100 is not medically necessary. According to drugs.com Klor-Con is used to prevent or to treat low blood levels of potassium (hypokalemia). Potassium levels can be low as a result of a disease or from taking certain medicines, or after a prolonged illness with diarrhea or vomiting. Klor-Con contains potassium chloride. Potassium is a mineral that is found in many foods and is needed for several functions of your body, especially the beating of your heart. On 09/17/2014, the injured worker's potassium level was 4.2. The submitted documentation has not indicated a history of hypokalemia or prescribed potassium supplements. Additionally, the request failed to include the frequency and duration of the medication. As such, the request for Klor-Con 8 mEq #100 is not medically necessary.

**1 spirometric lung function test to include pre and post bronchodilator:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pulmonary

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

**Decision rationale:** The request for 1 Spiro metric lung function test to include pre and post bronchodilator is not medically necessary. It is 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 Broncho constrictor (generally followed by a bronchodilator). The use of a Broncho constricting agent is termed "Broncho provocation" and commonly used agents include chemical agents (acetylcholine, meth choline, and putative occupational chemical exposures), physical agents (cold air, dry air), and exercise. 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. 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. 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. Furthermore the guidelines state that bronchodilators are under study. Epinephrine has long been used in the treatment of asthma. The beta component was found to cause bronchodilation and pharmaceutical companies have developed, over the years, more selective medications (B2 rather than B1 properties) that cause less side effects (sympathomimetic; generally the B1 component). These medications are separated into short and long acting preparations. The short acting medications (SABA or short acting bronchial antagonists) provide quick relief (minutes) that is short in duration (4-6 hours). Long acting sympathomimetic (LABAs) are used more on a prophylactic basis. They generally have an onset over many minutes (20-30) but can last for longer periods of time (12-24 hours). Some LABAs have some overlap with SABAs. Concern has been raised over the long-term safety of LABAs. There is some justification to the concept that LABAs, used by themselves (monotherapy), as a substitute for inhaled corticosteroids, are associated with increased rates of serious exacerbations, hospitalizations, and mortality. On 09/17/2014, the injured worker had undergone a Spirometric lung functioning test that revealed normal expiratory flow rates. The provider failed to include the rationale on why he was requesting a second study. The request for 1 Spirometric lung function test to include pre and post bronchodilator is not medically necessary.

#### **1 pulse oximetry screening test: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation National Clinical Guidelines Centre for Acute and Chronic Conditions. Chronic obstructive pulmonary disease. Management of chronic obstructive pulmonary disease in adults in primary and secondary care. London (UK): National Institute for Health and Clinical Excellence (NICE); 2010 Jun 61p. (Clinical guidelines ; no. 101)

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Summary of recommended key clinical activities for diagnoses and management of asthma. Management in the Urgent or Emergency Care Setting.

**Decision rationale:** The request for 1 pulse oximetry screening test is not medically necessary. Official Disability Guidelines state that monitoring response with serial assessment of lung function measures, pulse oximetry, and symptoms Considering adjunctive treatments such as magnesium sulfate or heliox in severe exacerbations (e.g. FEV1 or PEF < 40 percent predicted) unresponsive to initial treatment. On 09/17/2014, the injured worker had undergone a pulse oximetry study that revealed arterial oxygen saturation was 97% at rest on room air. The provider failed to indicate the rationale on why a second pulse oximetry screening test is being requested. As such, the request for 1 pulse oximetry screening test is not medically necessary.

#### **1 uric acid test: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Pinkerman C, Sander P, Breeding JE, Brink D, Curtis R, Hayes R, Ojha A, Pandita D, Raikar S, Setterlund L, Sule O, Turner A. Heart failure in adults. Bloomington (MN): Institute for Clinical Systems Improvement (ICSI); 2013 July page 94.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Labstestonline.org

**Decision rationale:** The request for a 1 uric acid test is not medically necessary. The California MTUS/ACOEM or the Official Disability Guidelines do not address this request. Per labstestonline.org indicates uric acid test is to detect high levels of uric acid in the blood, which could be a sign of the condition gout, or to monitor uric acid levels when undergoing chemotherapy or radiation treatment; to detect high levels of uric acid in the urine in order to diagnose the cause of kidney stones and to monitor those with gout who are at risk of developing such stones. When you have joint pain or other symptoms that your doctor suspects may be due to gout; when you have had or are going to have certain chemotherapy or radiation therapies for cancer; when you have recurrent kidney stones; when you have gout or are otherwise at risk for kidney stone formation. The injured worker had undergone a uric acid test on 09/17/2014 that was within normal limits. The provider failed to indicate the rationale for why he is requesting another study for a uric acid test for the injured worker. As such, the request for 1 uric acid test is not medically necessary.

**1 chem panel with lipids:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Pinkerman C, Sander P, Breeding JE, Brink D, Curtis R, Hayes R, Ojha A, Pandita D, Raikar S, Setterlund L, Sule O, Turner A. Heart failure in adults. Bloomington (MN): Institute for Clinical Systems Improvement (ICSI); 2013 July page 94.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Labstestonline.org

**Decision rationale:** The request for a Chem panel is not medically necessary. The California MTUS/ACOEM or the Official Disability Guidelines do not address this request. Therefore, please refer to the labtestsonline.org that indicates chemistry panels are groups of tests that are routinely ordered to determine a person's general health status. They help evaluate the body's electrolyte balance and/or the status of several major body organs. On 09/17/2014, the injured worker had undergone 1 Chem panel with lipids that revealed glucose was 119 and creatinine was 1.24. The provider failed to indicate the rationale for ordering a second study for 1 Chem panel with lipids. As such, the request for 1 Chem panel with lipids is not medically necessary.