

Case Number:	CM14-0128998		
Date Assigned:	08/15/2014	Date of Injury:	09/21/2007
Decision Date:	09/24/2014	UR Denial Date:	07/25/2014
Priority:	Standard	Application Received:	08/11/2014

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 Occupational Medicine and is licensed to practice in California. 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 claimant was injured on 09/21/07 while doing repetitive work duties. Pulmonary function/stress testing, sleep-disordered breathing respiratory study (at home), and overnight pulse oximetry and nasal function studies are under review. He has been diagnosed with sleep-related hypoventilation/ hypoxemia. He complains of headache with pain in the back of the neck radiating to the shoulders, elbows, arms, and forearms. He had tenderness with decreased range of motion of the neck and shoulders and the left long finger. He was given topical creams. He had observed apneas, daytime somnolence and nonrestorative sleep. His bed partners had observed apnea. He had nasal congestion and abnormal turbinates. The claimant had been using CPAP and BiPAP and allergy medication. He has a history of obstructive sleep apnea diagnosed in 2004 and heart bypass surgery performed in 2003. He was evaluated on 05/23/14 and is also diabetic and morbidly obese. He had sleep studies on 03/09/14. He was to follow-up with his primary treating physician according to Dr. [REDACTED]. He also has orthopedic problems including an injury to the cervical spine, shoulders, elbows, left wrist, left hand, anxiety, diabetes, and GERD. He was diagnosed with severe pathological sleep-related breathing respiratory disorder per Dr. [REDACTED] but it is not clear why he requires repeat studies. He also had cardiorespiratory diagnostic testing on 02/21/14 that included cardiovagal innervation, vasomotor adrenergic innervation, and EKG.

IMR ISSUES, DECISIONS AND RATIONALES

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

Pulmonary function, stress 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 (ODG), Treatment Index, 12th Edition (web), 2014, Pulmonary-Pulmonary function testing.

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 :Harrison's Principles of Internal Medicine textbook, Cardiovascular Chapters, Stress testing.

Decision rationale: The history and documentation do not objectively support the request for pulmonary function and [cardiac] stress testing. The MTUS do not address this type of testing. The ODG state regarding pulmonary function testing "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. (Colice, 2007) (Brunelli, 2007)"The textbook by Harrison's recommends cardiac stress testing when cardiac symptoms and findings on physical examination are present, in an effort to evaluate patients for ischemic heart disease.In this case, the specific indication for pulmonary function studies and [cardiac?] stress testing is not described and none can be ascertained from the records. There is no history of pulmonary symptoms such as asthma/COPD, toxic exposures, or any other conditions that warrant this type of workup. The claimant has had a diagnosis of obstructive sleep apnea for about 10 years and his course of treatment and response to treatment are unknown other than that he was using CPAP and BiPAP. It is not clear whether he has been worsening and may need other treatment such as surgery or is being cleared for possible surgery. He has a history of cardiac disease but there is no indication in the file of new or progressive cardiac symptoms. The indication for a [cardiac?] stress test has not been described and none can be ascertained from the records. The medical necessity of these studies has not been clearly demonstrated.

Sleep disordered breathing respiratory study (at home): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Treatment Index, 12th Edition (web), 2014, Pain-Sleep studies (Polysomnography).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation: AIM Specialty Health (AIM). Polysomnography and home sleep testing. Chicago (IL): AIM Specialty Health (AIM); 2014 Mar 25.

Decision rationale: The history and documentation do not objectively support the request for a sleep disordered breathing respiratory study (at home). The guideline listed above states "indications for Home (Unattended) Sleep Studies. Sleep testing may be classified as follows: Type I An attended sleep study performed in a hospital or freestanding sleep lab with continuous and simultaneous monitoring of electroencephalogram (EEG), electrooculogram (EOG), electrocardiogram (EKG), electromyogram (EMG), oxygen saturation, respiratory effort, and airflow. Type I studies are also known as polysomnography (PSG). Type IIA: sleep study (usually unattended) performed with portable equipment with continuous and simultaneous monitoring of EEG, EOG, EKG, EMG, oxygen saturation, respiratory effort, and airflow. Type II studies are similar to type I (PSG) studies except that the former are usually performed in the home. Type III: An unattended sleep study performed with portable equipment with monitoring of a minimum of four channels: 2 respiratory movement/airflow, 1 ECG/heart rate and 1 oxygen saturation. The studies are performed in the home and differ from types I and II in that they do not provide data on sleep staging. Type IV: An unattended sleep study performed with portable equipment with monitoring of three or fewer physiological parameters only one of which is airflow. The studies are performed in the home and differ from types I and II in that they do not provide data on sleep staging. Note: Home sleep studies performed with Type II and Type III devices (as defined above) are considered medically necessary when the criteria below are met. Type IV devices are considered to be not medically necessary in all clinical scenarios. Suspected Obstructive Sleep Apnea (OSA) Home sleep studies are indicated if the patient meets any of the following criteria (1-3) AND has no contraindication to a home sleep study as outlined in Table 1 in the original guideline document: 1. Observed apneas during sleep; OR 2. A combination of at least two (2) of the following (a-e): a. Excessive daytime sleepiness evidenced by an Epworth sleepiness scale score greater than 10, inappropriate daytime napping (e.g., during driving, conversation, or eating), or sleepiness that interferes with daily activities and is not explained by other conditions. b. Habitual snoring, or gasping/choking episodes associated with awakenings c. Treatment-resistant hypertension (persistent hypertension in a patient taking three or more antihypertensive medications) d. Obesity, defined as a body mass index greater than 30 kg/m² or increased neck circumference defined as greater than 17 inches in men or greater than 16 inches in women e. Craniofacial or upper airway soft tissue abnormalities, including adenotonsillar hypertrophy, or neuromuscular disease; OR 3. History of stroke (greater than 30 days previously) transient ischemic attack, coronary artery disease, or sustained supraventricular tachycardic or bradycardic arrhythmias in patients who meet one of the criteria in 2a-e above. Established OSA - Follow-up Home Sleep Studies: A patient with established diagnosis of OSA should have a follow-up home sleep study if either of the following applies AND there is no contraindication to

a home sleep study as outlined in the "Contraindications" field: 1. To assess efficacy of surgery (including adenotonsillectomy or upper airway) or oral appliances/devices; OR 2. To re-evaluate the diagnosis of OSA and need for continued continuous positive airway pressure (CPAP) if there is a significant weight loss (defined as 10% of body weight) since the most recent sleep study. The claimant has a diagnosis of sleep apnea and has been under treatment with CPAP and BiPAP. However, there is no clear evidence of worsening of his symptoms, intolerance to his current treatment with CPAP/BiPAP, or a significant change in treatment that is being considered. The claimant has had a diagnosis of obstructive sleep apnea for about 10 years and his course of treatment and response to treatment are unknown other than that he was using CPAP and BiPAP. It is not clear whether he has been worsening despite compliance with treatment or that other treatment is under consideration, such as surgery. The medical necessity of this at home sleep-disordered sleep respiratory study has not been clearly demonstrated.

Overnight pulse oximetry and nasal function studies: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Treatment Index, 12th Edition (web), 2014, Pain-Sleep studies (Polysomnography).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation: AIM Specialty Health (AIM). Polysomnography and home sleep testing. Chicago (IL): AIM Specialty Health (AIM); 2014 Mar 25.

Decision rationale: The history and documentation do not objectively support the request for overnight pulse oximetry and nasal function studies. The guideline listed above states "established Sleep Disorder (OSA or Other) - Follow-up Studies: A follow-up in-lab sleep study is appropriate in any of the following (1-5) situations: 1. A patient with established OSA continues to exhibit persistent snoring or other symptoms of sleep disordered breathing despite treatment with positive airway pressure therapy; OR 2. The patient has undergone adenotonsillectomy more than eight (8) weeks previously for management of established OSA; OR 3. To re-evaluate the diagnosis of OSA and need for continued positive airway pressure (PAP) if there is significant weight loss (defined as 10% of body weight) since the most recent sleep study; OR 4. To titrate CPAP or BPAP in a patient whose diagnostic study confirms that the patient is a candidate for positive airway pressure therapy and split-night study has not been performed or was inadequate; OR 5. The initial sleep study has led to a diagnosis other than OSA and the repeat study is requested because of a change in clinical status or to assess efficacy after a change in therapy. The claimant has a diagnosis of sleep apnea and has been under treatment with CPAP and BiPAP. However, there is no clear evidence of worsening of his symptoms, intolerance to his current treatment with CPAP/BiPAP or a significant change in treatment that is being considered. The claimant has had a diagnosis of obstructive sleep apnea for about 10 years and his course of treatment and response to treatment are unknown other than that he was using CPAP and BiPAP. It is not clear whether he has been worsening despite compliance with treatment or that other treatment is under consideration, such as surgery. The medical necessity of overnight pulse oximetry and nasal function studies has not been clearly demonstrated.