MAXIMUS Federal Services

Case Number:	CM15-0220643		
Date Assigned:	11/13/2015	Date of Injury:	10/08/2009
Decision Date:	12/23/2015	UR Denial Date:	10/29/2015
Priority:	Standard	Application Received:	11/09/2015

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: Montana
Certification(s)/Specialty: Preventive Medicine, Occupational 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 52 year old male who sustained an industrial injury on 10-08-2009. Medical records indicated the worker was treated for reactive airway disease, and chronic insomnia due to breathing difficulties. In the provider notes of 10-08-2015, the worker is seen for complaint of "lung problems." According to the provider notes, the worker has reactive airway disease incurred on the job. He complains his chest hurts "all the time." He has frequent wheezes and complains of difficulty sleeping due to breathing problems. Sleep is limited to 2-3 hours nightly. He awakens with headaches and has been experiencing some tremors in the neck. He complains of excessive coughing, discolored sputum production, wheezing, and pain with breathing. He denies coughing of blood. On exam, his lung has wheezes in the left upper quadrant. He has no crackles or rales and he is breathing normally. Inspection of his chest is within normal limits. A request for authorization was submitted for electrocardiography, pulmonary function test and sleep study. A utilization review decision on 10-29-2015 non-certified the request for electrocardiography, pulmonary function test and sleep study.

IMR ISSUES, DECISIONS AND RATIONALES

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

Electrocardiography: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation
www.nlm.nih.gov/medlineplus/ency/article/003868.htm.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Cardiology (ACC) and the American Heart Association (AHA) Guidelines for the use of ambulatory electrocardiography (ECG).

Decision rationale: The American College of Cardiology (ACC) and the American Heart Association (AHA), in collaboration with the North American Society for Pacing and Electrophysiology, have developed guidelines for the use of ambulatory electrocardiography (ECG). The guidelines include recommendations for the evaluation of symptoms of cardiac arrhythmias; for risk assessment in patients who have sustained a myocardial infarction, have congestive heart failure (CHF) or have hypertrophic cardiomyopathy; for the evaluation of antiarrhythmic therapy, or pacemaker or implantable cardioverter-defibrillator function; and for the evaluation of possible myocardial ischemia. According to the guidelines, it is widely accepted that ambulatory ECG monitoring provides accurate and clinically meaningful information about myocardial ischemia in patients with coronary artery disease. It is a Class IIb recommendation for evaluation of patients with chest pain who cannot exercise. In this case the medical records confirm a diagnosis of reactive airway disease as well as chronic pain secondary to multiple musculoskeletal issues which limits ability to exercise and complaints of chest pain. The request for ambulatory ECG is consistent with these recommendations and is a vital part of this injured worker's assessment. The request for electrocardiography is medically necessary.

Pulmonary function test: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, 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.

Decision rationale: The MTUS is silent on pulmonary function testing. The ODG guidelines note that pulmonary function testing 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 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) In this case the injured worker has a symptomatic chronic work related pulmonary condition for which periodic pulmonary function testing is appropriate for ongoing management. The request for pulmonary function test is medically necessary.

Sleep study: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, mental Illness and Stress, Polysomnography.

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

Decision rationale: The ODG guidelines state that polysomnography is recommended after at least six months of an insomnia complaint (at least four nights a week), unresponsive to behavior intervention and sedative/sleep-promoting medications, and after psychiatric etiology has been excluded. Not recommended for the routine evaluation of transient insomnia, chronic insomnia, or insomnia associated with psychiatric disorders. Home portable monitor testing may be an option. A polysomnogram measures bodily functions during sleep, including brain waves, heart rate, nasal and oral breathing, sleep position, and levels of oxygen saturation. It is administered by a sleep specialist, a physician who is Board eligible or certified by the American Board of Sleep Medicine, or a pulmonologist or neurologist whose practice comprises at least 25% of sleep medicine. (Schneider-Helmert, 2003) According to page 3-17 of the AMA Guides (5th ed), sleep disorder claims must be supported by formal studies in a sleep laboratory. (Andersson, 2000) However, home portable monitor testing is increasingly being used to diagnose patients with obstructive sleep apnea (OSA) and to initiate them on continuous positive airway pressure (CPAP) treatment, and the latest evidence indicates that functional outcome and treatment adherence in patients evaluated according to a home testing algorithm is not clinically inferior to that in patients receiving standard in-laboratory polysomnography. (Kuna, 2011) Insomnia is primarily diagnosed clinically with a detailed medical, psychiatric, and sleep history. Polysomnography is indicated when a sleep-related breathing disorder or periodic limb movement disorder is suspected, initial diagnosis is uncertain, treatment fails, or precipitous arousals occur with violent or injurious behavior. However, polysomnography is not indicated for the routine evaluation of transient insomnia, chronic insomnia, or insomnia associated with psychiatric disorders. (Littner, 2003) Polysomnograms / sleep studies are recommended for the combination of indications listed below: (1) Excessive daytime somnolence; (2) Cataplexy (muscular weakness usually brought on by excitement or emotion, virtually unique to narcolepsy); (3) Morning headache (other causes have been ruled out); (4) Intellectual deterioration (sudden, without suspicion of organic dementia); (5) Personality change (not secondary to medication, cerebral mass or known psychiatric problems); (6) Sleep-related breathing disorder or periodic limb movement disorder is suspected; (7) Insomnia complaint for at least six months (at least four 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; (8) Unattended (unsupervised) home sleep studies for adult patients are appropriate with a home sleep study device with a minimum of 4 recording channels (including oxygen saturation, respiratory movement, airflow, and EKG or heart rate). In this case there is no evidence for insomnia associated with psychiatric disorders. There is complaint of insomnia for at least 6 months and morning

headaches. He does have a diagnosis of a sleep related breathing disorder with a prior sleep study in January 2009 confirming a diagnosis of mild obstructive sleep apnea. There is no evidence that C-PAP was used. Given his ongoing complaints and worsening cardiopulmonary symptoms a sleep study is consistent with the ODG recommendations. The request for a sleep study is medically necessary and appropriate.