

<b>Case Number:</b>	CM13-0072374		
<b>Date Assigned:</b>	01/08/2014	<b>Date of Injury:</b>	07/01/2011
<b>Decision Date:</b>	06/27/2014	<b>UR Denial Date:</b>	12/09/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/30/2013

### 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 51-year-old female who reported an injury on 07/01/2011. The mechanism of injury was not provided for review. The injured worker's treatment history included chiropractic care, physical therapy, shockwave therapy, a TENS unit, and multiple medications. The injured worker was evaluated on 11/21/2013. Physical findings included trigger points of the paraspinal musculature bilaterally with decreased range of motion of the lumbar spine secondary to pain, and a positive straight leg raising test bilaterally. It was noted that the injured worker had decreased range of motion of the left knee and ankle. The injured worker had a positive McMurray's sign of the left knee and tenderness to palpation of the lateral ankle and medial ankle with painful range of motion. The injured worker's treatment plan included autonomic function assessment to assess for any pulmonary or respiratory abnormalities interfering with sleep function. However, the injured worker previously underwent a sleep study on 11/16/2013 and 11/15/2013. The study concluded that the patient suffered from a moderate sleep disorder. A request was made for additional testing.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**AUTONOMIC FUNCTION ASSESSMENT (CARDIO-RESPIRATORY DIAGNOSTIC TESTING):** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

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

**Decision rationale:** The requested AUTONOMIC FUNCTION ASSESSMENT (CARDIO-RESPIRATORY DIAGNOSTIC TESTING) is not medically necessary or appropriate. California Medical Treatment Utilization Schedule does not address this request. Official Disability Guidelines do not support the use of sleep studies unless the injured worker has had sleep dysfunction for a period longer than 6 months that has been unresponsive to pharmacological intervention. The clinical documentation did not provide any evidence that the injured worker has had an unsuccessful response to pharmacological intervention. Additionally, the clinical documentation does indicate that the injured worker has already participated in a sleep function study that has provided adequate results. Therefore, an additional study would not be indicated. As such, the requested AUTONOMIC FUNCTION ASSESSMENT (CARDIO-RESPIRATORY DIAGNOSTIC TESTING) is not medically necessary or appropriate.

**PULMONARY AND RESPIRATORY DIAGNOSTIC TESTING:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

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

**Decision rationale:** The requested PULMONARY AND RESPIRATORY DIAGNOSTIC TESTING is not medically necessary or appropriate. California Medical Treatment Utilization Schedule does not address this request. Official Disability Guidelines do not support the use of sleep studies unless the injured worker has had sleep dysfunction for a period longer than 6 months that has been unresponsive to pharmacological intervention. The clinical documentation did not provide any evidence that the injured worker has had an unsuccessful response to pharmacological intervention. Additionally, the clinical documentation does indicate that the injured worker has already participated in a sleep function study that has provided adequate results. Therefore, an additional study would not be indicated. As such, the requested PULMONARY AND RESPIRATORY DIAGNOSTIC TESTING is not medically necessary or appropriate.

**SDB (SLEEP-DISORDERED BREATHING) STUDY:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

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

**Decision rationale:** The requested SDB (SLEEP-DISORDERED BREATHING) STUDY is not medically necessary or appropriate. California Medical Treatment Utilization Schedule does not address this request. Official Disability Guidelines do not support the use of sleep studies unless the injured worker has had sleep dysfunction for a period longer than 6 months that has been unresponsive to pharmacological intervention. The clinical documentation did not provide any evidence that the injured worker has had an unsuccessful response to pharmacological intervention. Additionally, the clinical documentation does indicate that the injured worker has already participated in a sleep function study that has provided adequate results. Therefore, an additional study would not be indicated. As such, the requested SDB (SLEEP-DISORDERED BREATHING) STUDY is not medically necessary or appropriate.

**EVALUATION FOR CUSTOM FUNCTIONAL ORTHOTICS:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 14 Ankle and Foot Complaints Page(s): 374-375.

**Decision rationale:** The requested EVALUATION FOR CUSTOM FUNCTIONAL ORTHOTICS is not medically necessary or appropriate. The American College of Occupational and Environmental Medicine recommends the use of orthotics for the diagnosis of plantar fasciitis. The clinical documentation submitted for review does not indicate that the injured worker has a diagnosis of plantar fasciitis and would benefit from custom orthotics. There are no exceptional factors noted within the documentation to support extending treatment beyond guideline recommendations. As such, the requested EVALUATION FOR CUSTOM FUNCTIONAL ORTHOTICS is not medically necessary or appropriate.