

Case Number:	CM15-0108798		
Date Assigned:	06/15/2015	Date of Injury:	06/20/2010
Decision Date:	07/15/2015	UR Denial Date:	05/19/2015
Priority:	Standard	Application Received:	06/05/2015

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: Texas, Florida, California
 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 55-year-old female, who sustained an industrial injury on 6/20/12. She reported pain in her lower back. The injured worker was diagnosed as having status post lumbar spine fusion surgery times two. Treatment to date has included Oxycodone, Terocin patches, an overnight EEG, a pulmonary stress test and a cardio-respiratory test on 3/11/15 showing at least one of the two resting autonomic parameters is low. On 3/5/15, the injured worker reported slipping off a step stool and falling backwards. She landed on her buttocks and caught her foot in the stool. As of the PR2 dated 4/16/15, the injured worker reports constant low back pain that radiates to the left leg. She rates her pain a 6/10. Objective findings include lumbar flexion 35 degrees, extension 10 degrees and lateral 10 degrees bilaterally. She also has a positive straight leg raise test on the left. The treating physician requested cardio-respiratory, autonomic function assessment.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cardio-respiratory testing, autonomic function assessment: 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 <http://www.mdguidelines.com/coronary-atherosclerosis>, J Clin Neurol. 2013 Jan; 9 (1):1-8. doi: 10.3988/jcn.2013.9.1.1. E pub 2013 Jan 3. Autonomic function tests: some clinical applications. Low PA1, Tomalia VA, Park KJ.

Decision rationale: This claimant was injured in 2012 with low back pain. She is post lumbar fusion times two. A cardio respiratory test showed at least one of the two resting autonomic parameters is low. She had a new fall in March. There is constant low back pain. The current California web-based MTUS collection was reviewed in addressing this request. The guidelines are silent in regards to this request. Therefore, in accordance with state regulation, other evidence-based or mainstream peer-reviewed guidelines will be examined. The ODG is also silent. The Medical Disability Advisor was consulted for this review. Cardio respiratory testing is a broad term; which could encompass a wide variety of tests. For example, for coronary atherosclerosis alone, cited above, many tests exist for that purpose alone. The intent of these tests in this claimant is ill defined in this case. In this case, there is no evidence of cardiac issues or cardio respiratory symptoms noted. This request is appropriately non-certified as being clinically necessary for the claimant's condition. Regarding autonomic testing, the cited reference notes that modern autonomic function tests can non-invasively evaluate the severity and distribution of autonomic failure. They have sufficient sensitivity to detect even subclinical dysautonomia. Standard laboratory testing evaluates cardiovagal, sudomotor and adrenergic autonomic functions. Cardio vagal function is typically evaluated by testing heart rate response to deep breathing at a defined rate and to the Valsalva maneuver. Sudomotor function can be evaluated with the quantitative sudomotor axon reflex test and the thermoregulatory sweat test. Adrenergic function is evaluated by the blood pressure and heart rate responses to the Valsalva maneuver and to head-up tilt. Tests are useful in defining the presence of autonomic failure, their natural history, and response to treatment. However, this patient already had the testing, and it is not clear what was objectively accomplished to correct the previous findings. The role of a repeat is unclear. The request is appropriately not medically necessary.