

<b>Case Number:</b>	CM15-0120572		
<b>Date Assigned:</b>	07/06/2015	<b>Date of Injury:</b>	07/01/2014
<b>Decision Date:</b>	12/08/2015	<b>UR Denial Date:</b>	05/19/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/22/2015

### 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: 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 28-year-old male, who sustained an industrial injury on 7/1/14. He reported pain in his left side after a slip and fall accident. The injured worker was diagnosed as having cervical sprain, cervical radiculopathy, lumbar disc protrusion, lumbar radiculopathy, left shoulder derangement and obesity. Treatment to date has included physical therapy, a lumbar MRI on 10/10/14 showing multilevel degenerative changes of the lumbar spine, Norco and topical medications since at least 3/9/15. As of the PR2 dated 5/15/15, the injured worker reports constant pain in his neck, lower back and left shoulder. He rates his neck and low back pain a 7-8/10 and his left shoulder pain a 5/10 at this visit and an 8/10 without medications. Objective findings include cervical flexion is 40 degrees, extension is 40 degrees and rotation is 60 degrees bilaterally. He also has tenderness in the lumbar spine, a positive straight leg raise test on the left and decreased left shoulder range of motion. The treating physician requested cardiovascular innervation assessment, vasomotor adrenergic assessment, an EKG, a pulmonary function and stress test, a bilateral lower extremity EMG/NCV, a 2 night sleep disorder breathing respiratory test, Capsaicin 0.025%, Methyl Salicylate 25%, menthol 10%, Lidocaine 2.5% - 120 ml., Flurbiprofen 20%, Lidocaine 5%, Amitriptyline 4% 180 gms, Gabapentin 10%, Cyclobenzaprine 6%, Tramadol 10% - 180 gms., Genicin capsules #90 and Melatonin capsules #30.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Retrospective autonomic function assessment - cardiovagal innervation (DOS 2/4/15):**

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 Blue Cross and Blue Shield Association Corporate Medical Policy Subject: Autonomic Testing Policy #: MED.00112 Current Effective Date: 10/06/2015 Status: Revised Last Review Date: 08/06/2015.

**Decision rationale:** The Official Disability Guidelines and the MTUS are silent on this issue. [REDACTED] association corporate medical policy is the following: The use of autonomic nervous system function testing for sudomotor function using quantitative sudomotor axon reflex test (QSART), the thermoregulatory sweat test (TST), silastic sweat imprint, sympathetic skin response (SSR), quantitative direct and indirect reflex test of sudomotor function (QDIRT), or SudoScan are considered investigational and not medically necessary for all indications. The use of autonomic nervous system function testing for cardiovagal innervations is considered investigational and not medically necessary for all indications. The use of autonomic nervous system function testing for vasomotor adrenergic innervations is considered investigational and not medically necessary for all indications. The above Guidelines state that insufficient evidence exists to support the use of autonomic function assessment cardiovagal innervations outside the investigational setting. The treating physician does not provide documentation of extenuating circumstances, which would substantiate deviating from the Guidelines. Retrospective autonomic function assessment cardiovagal innervation (DOS 2/4/15) is not medically necessary.

**Retrospective autonomic function assessment - vasomotor adrenergic (DOS 2/4/15):** 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 Blue Cross and Blue Shield Association Corporate Medical Policy Subject: Autonomic Testing Policy #: MED.00112 Current Effective Date: 10/06/2015 Status: Revised Last Review Date: 08/06/2015.

**Decision rationale:** The Official Disability Guidelines and the MTUS are silent on this issue. [REDACTED] association corporate medical policy is the following: The use of autonomic nervous system function testing for sudomotor function using quantitative sudomotor axon reflex test (QSART), the thermoregulatory sweat test (TST), silastic sweat imprint, sympathetic skin response (SSR), quantitative direct and indirect reflex test of sudomotor function (QDIRT), or SudoScan are considered investigational and not medically necessary for all indications. The use of autonomic nervous system function testing for cardiovagal innervations is considered investigational and not medically necessary

for all indications. The use of autonomic nervous system function testing for vasomotor adrenergic innervations is considered investigational and not medically necessary for all indications. The above Guidelines state that insufficient evidence exists to support the use of autonomic function assessment vasomotor adrenergic outside the investigational setting. The treating physician does not provide documentation of extenuating circumstances, which would substantiate deviating from the Guidelines. Retrospective autonomic function assessment - vasomotor adrenergic (DOS 2/4/15) is not medically necessary.

**Retrospective autonomic function assessment - EKG (DOS 2/4/15): 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 Blue Cross and Blue Shield Association Corporate Medical Policy Subject: Autonomic Testing Policy #: MED.00112 Current Effective Date: 10/06/2015 Status: Revised Last Review Date: 08/06/2015.

**Decision rationale:** The Official Disability Guidelines and the MTUS are silent on this issue. [REDACTED] association corporate medical policy is the following: The use of autonomic nervous system function testing for sudomotor function using quantitative sudomotor axon reflex test (QSART), the thermoregulatory sweat test (TST), silastic sweat imprint, sympathetic skin response (SSR), quantitative direct and indirect reflex test of sudomotor function (QDIRT), or SudoScan are considered investigational and not medically necessary for all indications. The use of autonomic nervous system function testing for cardiovascular innervations is considered investigational and not medically necessary for all indications. The use of autonomic nervous system function testing for vasomotor adrenergic innervations is considered investigational and not medically necessary for all indications. The above Guidelines state that insufficient evidence exists to support the use of autonomic function assessment EKG outside the investigational setting. The treating physician does not provide documentation of extenuating circumstances, which would substantiate deviating from the Guidelines. Retrospective autonomic function assessment EKG (DOS 2/4/15) is not medically necessary.

**Pulmonary function and stress test: 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) Pulmonary (Acute & Chronic), Pulmonary function testing.

**Decision rationale:** The Official Disability Guidelines recommend spirometry and pulmonary function testing of the diagnosis and management of chronic lung diseases, most notably asthma. In addition, pulmonary function testing it is sometimes utilized in a preoperative evaluation of a patient with pulmonary compromise. There is no documentation of any of the above criteria. Pulmonary function and stress test is not medically necessary.

**EMG - right lower extremity: 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) Low Back - Lumbar & Thoracic (Acute & Chronic), EMGs (electromyography).

**Decision rationale:** According to the Official Disability Guidelines, EMG's are recommended as an option and may be useful to obtain unequivocal evidence of radiculopathy, after 1-month conservative therapy, but EMG's are not necessary if radiculopathy is already clinically obvious. This patient carries a diagnosis of lumbar radiculopathy. The clinical information submitted for review fails to meet the evidence-based guidelines for the requested service. EMG right lower extremity is not medically necessary

**EMG - left lower extremity: 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) Low Back - Lumbar & Thoracic (Acute & Chronic), EMGs (electromyography).

**Decision rationale:** According to the Official Disability Guidelines, EMG's are recommended as an option and may be useful to obtain unequivocal evidence of radiculopathy, after 1-month conservative therapy, but EMG's are not necessary if radiculopathy is already clinically obvious. This patient carries a diagnosis of lumbar radiculopathy. The clinical information submitted for review fails to meet the evidence-based guidelines for the requested service. EMG left lower extremity is not medically necessary.

**NCV - right lower extremity: 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) Low Back - Lumbar & Thoracic (Acute & Chronic), Nerve conduction studies (NCS).

**Decision rationale:** According to the Official Disability Guidelines, nerve conduction studies are not recommended. Neurological testing procedures have limited overall diagnostic accuracy in detecting disc herniation with suspected radiculopathy. There is minimal justification for performing nerve conduction studies when a patient is presumed to have symptoms based on radiculopathy. This patient carries a diagnosis of lumbar radiculopathy. NCV right lower extremity is not medically necessary.

**NCV - left lower extremity: 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) Low Back - Lumbar & Thoracic (Acute & Chronic), Nerve conduction studies (NCS).

**Decision rationale:** According to the Official Disability Guidelines, nerve conduction studies are not recommended. Neurological testing procedures have limited overall diagnostic accuracy in detecting disc herniation with suspected radiculopathy. There is minimal justification for performing nerve conduction studies when a patient is presumed to have symptoms based on radiculopathy. This patient carries a diagnosis of lumbar radiculopathy. NCV left lower extremity is not medically necessary.

**Capsaicin 0.025%, Methyl Salicylate 25%, menthol 10%, Lidocaine 2.5% - 120 ml.: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics.

**Decision rationale:** According to the MTUS, there is little to no research to support the use of many of these Compounded Topical Analgesics. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Capsaicin topical is recommended only as an option in patients who have not responded or are intolerant to other treatments. The medical record contains no documentation that the patient is intolerant of unresponsive to other treatments. Capsaicin 0.025%, Methyl Salicylate 25%, menthol 10%, Lidocaine 2.5% - 120 ml is not medically necessary.

**Flurbiprofen 20%, Lidocaine 5%, Amitriptyline 4% - 180 gms.: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics.

**Decision rationale:** According to the MTUS, there is little to no research to support the use of many of these compounded topical analgesics. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. Flurbiprofen topical is not supported by the MTUS. Flurbiprofen 20%, Lidocaine 5%, Amitriptyline 4% - 180 gms is not medically necessary.

**Gabapentin 10%, Cyclobenzaprine 6%, Tramadol 10% - 180 gms.: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics.

**Decision rationale:** According to the MTUS, there is little to no research to support the use of many of these compounded topical analgesics. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Gabapentin is not recommended. There is no peer-reviewed literature to support use. Gabapentin 10%, Cyclobenzaprine 6%, Tramadol 10% 180 gms. is not medically necessary.

**Genicin capsules #90:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Glucosamine (and Chondroitin Sulfate).

**Decision rationale:** According to the MTUS, glucosamine is recommended as an option in patients with moderate arthritis pain, especially for knee osteoarthritis. Studies have demonstrated a highly significant efficacy for crystalline glucosamine sulphate (GS) on all outcomes, including joint space narrowing, pain, mobility, safety, and response to treatment, but similar studies are lacking for glucosamine hydrochloride (GH). This patient does not carry a diagnosis of arthritis. The Official Disability Guidelines do not recommend glucosamine for lumbar sprain/strains. Genicin capsules #90 is not medically necessary.

**Somnicin (Melatonin 5HTTP) capsules #30:** Upheld

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

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

**Decision rationale:** The Official Disability Guidelines recommend a melatonin as a single agent to improve sleep. The repeated administration of melatonin improves sleep and thereby may reduce anxiety, which leads to lower levels of pain. Somnicin is a compounded medication. Melatonin compounded with other substances is not recommended. Somnicin (Melatonin 5HTTP) capsules #30 is not medically necessary.

**Sleep disordered breathing respiratory testing - 2 night study:** Upheld

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

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

**Decision rationale:** According to the Official Disability Guidelines, in-lab 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) 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 without one of the above-mentioned symptoms is not recommended. The PR-2 associated with the request for authorization gave no clear rationale as to why a sleep study would be necessary. Sleep disordered breathing respiratory testing 2 night study is not medically necessary.