MAXIMUS Federal Services

| Case Number: | CM15-0046941 | | |
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| Date Assigned: | 03/19/2015 | Date of Injury: | 06/01/2011 |
| Decision Date: | 05/01/2015 | UR Denial Date: | 02/19/2015 |
| Priority: | Standard | Application Received: | 03/12/2015 |

## 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: District of Columbia, Virginia
Certification(s)/Specialty: Internal 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 51-year-old female, who sustained an industrial injury on 3/10/2012. She reported injury to the bilateral wrists and low back pain. The injured worker was diagnosed as having anxiety, depression and low back pain with bilateral lower extremities radiculopathy. There is no record of a recent radiology studies. Treatment to date has included psychiatric services and medication management. Currently, the injured worker complains of depression, sleep disturbance, lack of motivation, decreased energy, pessimism and chest pain. In a progress note dated 2/23/2015, the treating physician is requesting Cardio-Respiratory testing and Sudoscan.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Cardio-Respiratory Testing:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 2 General Approach to Initial Assessment and Documentation, Chronic Pain Treatment Guidelines.

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

battery, pulmonary chapter www.cms.gov/MCD/viewlcd.asp
lcd_id=28255&lcd_version=19&show=allc.

**Decision rationale:** Per the clinical documentation provided, the indication and type of cardiorespiratory testing is not provided and therefore would not be indicated. Per ODG, autonomic test battery is not recommended as a diagnostic test for CRPS. Per Medicare and Medicaid guidelines, 1. An electrocardiogram (EKG) is a graphic representation of electrical activity within the heart. Electrodes placed on the body in predetermined locations sense this electrical activity, which is then recorded by various means for review and interpretation. EKG recordings are used to diagnose a wide range of heart disease and other conditions that manifest themselves by abnormal cardiac electrical activity. EKG services are covered diagnostic tests when there are documented signs and symptoms or other clinical indications for providing the service. Coverage includes the review and interpretation of EKGs only by a physician. There is no coverage for EKG services when rendered as a screening test or as part of a routine examination unless performed as part of the one-time, Welcome to Medicare- preventive physical examination under section 611 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. Descriptions of Ambulatory EKG Monitoring Technologies 1. Dynamic electrocardiography devices that continuously record a real-time EKG, commonly known as holter TM monitors, typically record over a 24-hour period. The recording is captured either on a magnetic tape or other digital medium. The data is then computer-analyzed at a later time, and a physician interprets the computer-generated report. A 24-hour recording is generally adequate to detect most transient arrhythmias. Documentation of medical necessity is required for monitoring longer than 24 hours. The recording device itself is not covered as durable medical equipment (DME) separate from the total diagnostic service. 2. An event monitor, or event recorder, is a patient-activated or event-activated EKG device that intermittently records cardiac arrhythmic events as they occur. The EKG is recorded on magnetic tape or other digital medium. Cardiac event monitor technology varies among different devices. For patient-activated event monitors, the patient initiates recording when symptoms appear or when instructed to do so by a physician (e.g., following exercise). For self-sensing, automatically triggered monitors, an EKG is automatically recorded when the device detects an arrhythmia, without patient intervention. Some devices permit a patient to transmit EKG data transtelephonically (i.e., via telephone) to a receiving center where the data is reviewed. A technician may be available at these centers to review transmitted data 24 hours per day. In some instances, when the EKG is determined to be outside certain pre-set criteria by a technician or other non-physician, a physician is available 24 hours per day to review the transmitted data and to make clinical decisions regarding the patient. These services are known as "24-hour attended monitoring." In other instances, transmitted EKG data is reviewed at a later time and are, therefore, considered non-attended. Per ODG, pulmonary function testing(PFT) is recommend as follows: separated into simple spirometry and complete pulmonary function testing. The simple spirometry will measure the forced vital capacity and provide a variety of airflow rates such as forced expiratory volume in one second and the forced expiratory flow between 25-75% of the total exhale volume. The complete PFT adds tests of the lung volumes and the diffusing lung capacity for carbon monoxide. Lung volumes can be assessed by traditional methods or by using plethysmography, requiring 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 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, physical agents and exercise (Birnbaum 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. 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 requested treatement is not medically necessary.

**Sudoscan:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 2 General Approach to Initial Assessment and Documentation,Chronic Pain Treatment Guidelines.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3817891/.

**Decision rationale:** ACOEM and MTUS do not address this issue. Alternate guidelines were sought. Sudomotor dysfunction may be an early detectable abnormality in diabetic small fiber neuropathy. The aim of this study was to evaluate the efficacy of Sudoscan [redacted], [redacted]) in detecting diabetic neuropathy (DN), in comparison with other standardized tests, in patients with diabetes mellitus (DM). This study shows that: ESC of hands and feet is decreased in patients with DN diagnosed using the current Toronto classification of DPN, 1 compared with HCs and DM patients without neuropathy. Sudoscan results correlate significantly with clinical measures of neuropathy, somatic and autonomic function testing, and pain scores. Sudoscan is a sensitive tool to detect neuropathy in patients with DM, with a sensitivity of 78% and a specificity of 92%, equivalent to or better than clinical neuropathy scores. Feet ESC was significantly decreased in patients with painful DN compared with the value in patients with nonpainful neuropathy. Test-retest reliability is excellent for the feet. These results suggest that sudomotor function, evaluated through reverse iontophoresis (Sudoscan), is a reliable option when evaluating diabetes patients for the detection of small fiber neuropathy and peripheral autonomic neuropathy. Combined with a simple bedside test as the NIS-LL, Sudoscan may increase the effectiveness in detecting neuropathy. Per review of the clinical documentation provided, there is no evidence that the patient had been diagnosed with DM or DN. It is not apparent why this test was ordered. The requested treatment is not medically necessary.