

<b>Case Number:</b>	CM15-0082956		
<b>Date Assigned:</b>	05/05/2015	<b>Date of Injury:</b>	11/17/2014
<b>Decision Date:</b>	07/14/2015	<b>UR Denial Date:</b>	04/03/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/29/2015

### 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 64 year old female, who sustained an industrial injury on 11/17/2014. She has reported injury to the right shoulder, low back, right foot, and bilateral knees. The diagnoses have included foot sprain/strain; neuralgia, neuritis, and radiculitis, unspecified; knee sprain/strain; lumbar sprain/strain; and shoulder sprain/strain. Treatment to date has included medications, diagnostics, and physical therapy. Medications have included Tramadol. A progress note from the treating physician, dated 03/24/2015, documented a follow-up visit with the injured worker. Currently, the injured worker complains of low back pain; right shoulder pain; pain in both knees; and pain in the right foot. Objective findings included decreased range of motion of the lumbar spine, with increased pain and muscle spasms L1-S1; decreased range of motion in the bilateral knees, with increased pain and tenderness in the medial and lateral joint lines; right shoulder tenderness, with increased pain at the anterior, posterior, acromioclavicular joint with impingement; and decreased range of motion to the right foot, with increased pain and tenderness over the medial aspect of the foot, plantar surface. The treatment plan has included the request for one (1) automatic nervous system sudomotor testing; one (1) spirometry and pulmonary function and stress testing; one (1) sleep disorder breathing respiratory study; 6 physical therapy visits for the lumbar spine, right shoulder, right foot, and bilateral knees; and 6 chiropractic sessions for the lumbar spine, right shoulder, right foot, and bilateral knees.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**One (1) automatic nervous system sudomotor testing: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter, CRPS Testing.

**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: 10/14/2014 Status: Revised Last Review Date: 08/14/2014.

**Decision rationale:** The Official Disability Guidelines and the MTUS are silent on this issue. The Blue Cross and Blue Shield 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. One (1) automatic nervous system sudomotor testing is not medically necessary.

**One (1) spirometry and pulmonary function and stress testing: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), 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, 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. One (1) spirometry and pulmonary function and stress testing is not medically necessary.

**One (1) sleep disorder breathing respiratory 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 (ODG), Pain Chapter, Polusomnography Section.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation 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 for the sole complaint of snoring, without one of the above mentioned symptoms, is not recommended. There is no documentation of the above criteria. One (1) sleep disorder breathing respiratory study is not medically necessary.

**6 physical therapy visits for the lumbar spine, right shoulder, right foot and bilateral knee:**  
Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 9792.20 - 9792.26 Page(s): 58-60.

**Decision rationale:** The MTUS Chronic Pain Medical Treatment Guidelines state that active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. Continued physical therapy is predicated upon demonstration of a functional improvement. There is no documentation of objective functional improvement. In addition, California Labor Code Section 4604.5(c) (1) states that an employee shall be entitled to no more than 24 chiropractic, 24 occupational therapy, and 24 physical therapy visits per industrial injury. Patient has completed 19 sessions of physical therapy to date. 6 physical therapy visits for the lumbar spine, right shoulder, right foot and bilateral knee is not medically necessary.

**6 chiropractic sessions for the lumbar spine, right shoulder, right foot and bilateral knees:**  
Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy and Manipulation Section Page(s): 58.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 9792.20 - 9792.26 Page(s): 58-60.

**Decision rationale:** The MTUS Chronic Pain Medical Treatment Guidelines state that active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. Continued physical therapy is predicated upon demonstration of a functional improvement.

There is no documentation of objective functional improvement. 6 chiropractic sessions for the lumbar spine, right shoulder, right foot and bilateral knees is not medically necessary.