

Case Number:	CM14-0122721		
Date Assigned:	09/16/2014	Date of Injury:	02/27/2014
Decision Date:	10/24/2014	UR Denial Date:	07/28/2014
Priority:	Standard	Application Received:	08/04/2014

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 Internal Medicine and is licensed to practice in California. 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 45-year-old female who reported an injury on 02/27/2014. The injury reportedly occurred when the injured worker was sitting in a row of chairs that collapsed. The treatment history included medications, aquatic therapy and physical therapy. The injured worker was evaluated on 06/30/2014 and is documented that the injured worker complained of back and wrist pain. Physical examination revealed there was tenderness to palpation over thoracic and lumbar paraspinal muscles. There was facet tenderness to palpation at the L4-S1 levels. Kemp's test was positive bilaterally. Seated straight leg raise was positive at 60 degrees at the right and 70 degrees at the left. Supine straight leg raise was positive at 50 degrees at the right and 60 degrees at the left. Farfan's test was positive bilaterally. Lateral bending was 20 degrees bilaterally. Flexion was 65 degrees and extension was 10 degrees. There was decreased sensation along the L5 dermatomal distributions bilaterally as to pain, temperature, light touch, vibration and 2 point discrimination, bilateral neural foraminal narrowing. She had undergone an EMG/NCV studies that revealed a bilateral active L5 radiculopathy on 04/09/2014. On 06/26/2014, the injured worker had undergone a sudomotor function assessment that revealed the injured worker exhibiting normal symmetry and levels of conductance on hands and feet. It was recommended that the injured worker retest in 6 months in order to check for any changes in the injured worker's levels. If the injured worker developed or exhibited signs of glucose intolerance or autonomic neuropathic symptoms before the next testing date, a follow-up diagnostic test was recommended at that time. Medications include Naproxen, Soma, Norco, Paxil, and Flexeril. Diagnoses include lumbar spine discopathy, lumbar spine radiculopathy, lumbar facet syndrome, bilateral sacroiliac joint arthropathy and leg pain. The Request for Authorization was not submitted for this review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Sudoscans - Sudomotor function assessment (DOS 06/26/14): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation <http://www.ncbi.nlm.nih.gov/pubmed/16464634> and Medical Policy Manual

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Sudomotor & CRPS Diagnostic Testing.

Decision rationale: The requested is not medically necessary. Per the Official Disability Guidelines (ODG) does not recommend as a diagnostic test for CRPS. Sudomotor measures: Most formal diagnostic tests for this are laboratory based and not generally recommended. Tests include (1) the iontophoretic quantitative sudomotor axon reflex test (QSART), (2) the sialastic sweat imprint method, (3) the thermoregulatory sweat test (TST), (4) sympathetic skin response and related electrodermal activity, (5) sympathetic skin resistance and selective tissue conductance, (6) quantitative sensory testing (QST), (7) resting sweat output (RSO). The injured worker had orthopedic complaints. Current documentation denied cardio/pulmonary condition and autonomic neuropathic symptoms. Furthermore, the documentation for clinical findings is inadequate to suspect complaints concerning cardiac, respiratory, and autonomic nervous system disturbances. Therefore, the request for Sudoscans - Sudomotor function assessment (DOS 06/26/14) is not medically necessary.

Sleep disordered breathing respiratory study: two nights at claimant's residence, including pulse oximetry and nasal function (DOS: 07/09/14, 07/10/14): 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) - TWC Pain Procedure Summary last updated 06/10/2014 Criteria for Polysomnography:

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Polosomnography & Pulmonary. Pulmonary Function Testing.

Decision rationale: The requested is not medically necessary. Per the Official Disability Guidelines (ODG) recommends polysomnography after at least six months of an insomnia complaint (at least four nights a week), unresponsive to behavior intervention and sedative/sleep-promoting medications, and after psychiatric etiology has been excluded. Not recommended for the routine evaluation of transient insomnia, chronic insomnia, or insomnia associated with psychiatric disorders. Home portable monitor testing may be an option. A polysomnogram measures bodily functions during sleep, including brain waves, heart rate, nasal and oral breathing, sleep position, and levels of oxygen saturation. It is administered by a sleep specialist, a physician who is Board eligible or certified by the American Board of Sleep Medicine, or a

pulmonologist or neurologist whose practice comprises at least 25% of sleep medicine. According to page 3-17 of the AMA Guides (5th ed), sleep disorder claims must be supported by formal studies in a sleep laboratory. However, home portable monitor testing is increasingly being used to diagnose patients with obstructive sleep apnea (OSA) and to initiate them on continuous positive airway pressure (CPAP) treatment, and the latest evidence indicates that functional outcome and treatment adherence in patients evaluated according to a home testing algorithm is not clinically inferior to that in patients receiving standard in-laboratory polysomnography. Insomnia is primarily diagnosed clinically with a detailed medical, psychiatric, and sleep history. The guidelines also state that pulmonary function testing is recommended. Separated into simple spirometry and complete pulmonary function testing. The simple spirometry will measure the forced vital capacity (FVC) and provides a variety of airflow rates such as the forced expiratory volume in one second (FEV1) and the forced expiratory flow between 25-75% of the total exhaled volume (FEF25-75). The complete pulmonary function test (PFT) adds tests of the lung volumes and the diffusing capacity for carbon monoxide (DLCO). Lung volumes can be assessed by traditional methods or by using plethysmography, requiring the 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 the 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 (acetylcholine, methacholine, and putative occupational chemical exposures), physical agents (cold air, dry air), and exercise. Also useful in asthmatics is the use of peak flow meters to determine the presence of asthma, the response to treatment, and exacerbations of asthma. The injured worker had low back pain and clinical deficits on physical examination. However, there is no documentation of complaints of difficulty of breathing and objective findings of pulmonary deficits. There was no documentation of snoring, witnessed apneas, gasping arousal, and night-time sleep fragmentation. As such, the request for Sleep disordered breathing respiratory study: two nights at claimant's residence, including pulse oximetry and nasal function (DOS: 07/09/14, 07/10/14) is not medically necessary.