

Case Number:	CM15-0018487		
Date Assigned:	02/06/2015	Date of Injury:	12/03/2013
Decision Date:	03/31/2015	UR Denial Date:	01/08/2015
Priority:	Standard	Application Received:	01/30/2015

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: Minnesota, Florida

Certification(s)/Specialty: Orthopedic Surgery

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 25 year old female who sustained an industrial injury to the left knee on December 3, 2013. The injured worker underwent multiple knee aspirations. Magnetic resonance imaging (MRI) of the knee performed on September 5, 2014 documented a focal subacute to chronic subchondral fracture of the medial femoral condyle with adjacent marrow edema. The injured worker was diagnosed with lumbar spine sprain/strain, lumbosacral radiculitis, left foot and ankle tenosynovitis, and left knee internal derangement with subchondral fracture. A left knee arthroscopy has been authorized. Current medications are Ibuprofen and topical analgesics. Prior treatment modalities consist of physical therapy (6 sessions), home exercise program, acupuncture therapy, knee brace/immobilizer, assistive walking devices, aspirations of the knee, cortisone injections and medication. The injured worker is on temporary total disability (TTD). The treating physician requested authorization for Autonomic Nervous System and Sudoscan testing to measure alterations as a response to parasympathetic and sympathetic system stimulation to determine possible autonomic dysfunction. On January 8, 2015 the Utilization Review denied certification for Autonomic Nervous System and Sudoscan testing. Citations used in the decision process were the Medical Treatment Utilization Schedule (MTUS), American College of Occupational and Environmental Medicine (ACOEM), Surgical Considerations, the Official Disability Guidelines (ODG) and alternative guidelines.

IMR ISSUES, DECISIONS AND RATIONALES

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

Autonomic nervous system and Sudoscan testing: 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/pmc/articles/PMC3817891/>

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Blue Cross Blue Shield of Alabama Autonomic Nervous System Testing criteria Sudoscan www.ncbi.nlm.nih.gov/ national Center for biotechnology information by CM Casellini 2013

Decision rationale: California MTUS and ODG do not address this topic. Alternate guidelines are used. AUTONOMIC NERVOUS SYSTEM TESTING consists of a battery of tests in several domains. The criteria for testing include: Signs and/or symptoms of autonomic dysfunction are present and a definitive diagnosis cannot be made from clinical examination and routine laboratory testing alone and diagnosis of the suspected autonomic disorder will lead to a change in management or will eliminate the need for further testing. Although there is not a standard battery of tests that are part of ANS testing, a full battery of testing generally consists of individual tests in 3 domains. Cardio vagal function (heart rate variability, heart rate response to deep breathing and Valsalva) vasomotor adrenergic function (blood pressure response to standing, Valsalva and hand grip, tilt table testing) pseudomotor function (QSART, QST, DSD, Silastic sweat test) at least 1 test in this category is usually performed. The disorders studied included distal small fiber neuropathy, diabetic polyneuropathy, Parkinson's multisystem atrophy, painful neuropathy, adrenergic failure, ANS Disorders also called dysautonomias are heterogeneous in etiology, clinical symptoms, and severity. ANS disorders can be limited and focal such as patients with isolated neurocardiogenic syncope or idiopathic palmar hyperhidrosis. The documentation submitted does not indicate the presence of these disorders and ANS testing is therefore not medically necessary. With regard to Sudoscan: Sudomotor dysfunction may be an early detectable abnormality in diabetic small fiber neuropathy. Sudoscan measures Electrochemical skin conductance of hands and feet through reverse iontophoresis. Diabetic patients with diabetic neuropathy had significantly worse electrochemical skin conductance of feet and hands than diabetes mellitus patients without diabetic neuropathy and healthy controls. The documentation does not indicate the presence of diabetes and as such, a sudoscan is not medically necessary. Based upon the above the requests for ANS and Sudoscan testing are not supported and as such, the medical necessity is not substantiated.