

Case Number:	CM14-0140135		
Date Assigned:	10/13/2014	Date of Injury:	02/06/2003
Decision Date:	11/19/2014	UR Denial Date:	08/07/2014
Priority:	Standard	Application Received:	08/29/2014

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 Occupational 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:

Patient is a 38-year-old male with date of injury 02/06/2003. The medical document associated with the request for authorization, a primary treating physician's progress report, dated 06/27/2014, lists subjective complaints as: 1. Internal 2. Left kidney 3. Left foot 4. Left eye 5. Left forearm 6. Skin 7. Nose. Objective findings: Patient admits blurred and double vision from his left eye. Patient underwent surgery to have his thyroid gland removed. Patient admits musculoskeletal pain on his left lower extremity. Edema was noted in the left lower extremity and hip. Tenderness to palpation was noted over the lumbosacral paravertebral muscles. Diagnosis: 1. History of nose bleeds 2. Left eye trauma 3. Elevated blood pressure 4. Status post right kidney transplant 5. Orthopedic diagnosis, referred to appropriate specialist. The medical records supplied for review document that the patient was first prescribed the following medication on 06/27/2014. Medications: 1. Topical Cream: Gabapentin 10%/Amitriptyline 10%/Dextromethorphan 10% in Mediderm base 210gm.

IMR ISSUES, DECISIONS AND RATIONALES

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

ICG: 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 Other Medical Treatment Guideline or Medical Evidence: Blue Cross and Blue Shield Association Corporate Medical Policy Cardiac Hemodynamic Monitoring in the Outpatient Setting Last Reviewed 10/2014

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: Bio impedance is defined as the electrical resistance of tissue to the flow of current. The technique is alternatively known as impedance plethmography and impedance cardiography (ICG). Changes in bio impedance, measured at each beat of the heart, are inversely related to pulsatile changes in volume and velocity of blood in the aorta. Cardiac output is the product of stroke volume by heart rate, and thus can be calculated from bio impedance. Cardiac hemodynamic monitoring in the outpatient setting is considered investigational for all applications. ICG is not medically necessary.

2D echo with doppler: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Cardiology/American Heart Association Task Force on Practice Guidelines

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Aetna Clinical Policy Bulletin: Color-Flow Doppler Echocardiography in Adults Policy reviewed September 2013

Decision rationale: The Official Disability Guidelines in the MTUS are silent on this issue. The Aetna Clinical Policy Guidelines state the following: Aetna considers color-flow (2D Echo) Doppler echocardiography in adults medically necessary for the following indications: Evaluation of aortic diseases, Evaluation of aortocoronary bypass grafts, Evaluation of hypertrophic cardiomyopathy (formerly known as idiopathic hypertrophic subaortic stenosis), Evaluation of prosthetic valves, Evaluation of septal defects, Evaluation of site of left-to-right or right-to-left shunts and Evaluation of the severity of valve stenosis and regurgitation. Aetna considers color-flow Doppler echocardiography in adults experimental and investigational for all other indications. The medical record fails to document any of the above indications for 2-D echo with Doppler. 2D echo with Doppler is not medically necessary.

Cardio-respiratory testing to include autonomic function assessment, cardiovagal innervation, vasomotor adrenergic innervation: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Cardiology/American Heart Association Task Force on Practice Guidelines

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical

Evidence: 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 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. Cardio-respiratory testing to include autonomic function assessment, cardiovagal innervation, and vasomotor adrenergic innervation are not medically necessary.

Sudoscan: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Cardiology/American Heart Association Task Force on Practice Guidelines

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: 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 pseudomotor function using quantitative pseudomotor axon reflex test (QSART), the thermoregulatory sweat test (TST), silastic sweat imprint, sympathetic skin response (SSR), quantitative direct and indirect reflex test of pseudomotor function (QDIRT), or SudoScan are considered investigational and not medically necessary for all indications. SudoScan is not medically necessary.

Topical compound Gabapentin10%/Amitriptyline10%/Dextromethrophan10% in mediderm base 210gm: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111-113.

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. Topical compound

Gabapentin10%/Amitriptyline10%/Dextromethrophan10% in mediderm base 210gm is not medically necessary.