

Case Number:	CM14-0106951		
Date Assigned:	08/01/2014	Date of Injury:	05/05/2011
Decision Date:	09/09/2014	UR Denial Date:	06/12/2014
Priority:	Standard	Application Received:	07/10/2014

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 Physical Medicine & Rehabilitation, has a subspecialty in Pain Medicine and is licensed to practice in Texas and Oklahoma. 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 57-year-old male who reported an injury on 05/05/2011 due to falling off a ladder. The injured worker has diagnoses of GERD, constipation, status post right total knee replacement, chronic low back pain, chronic pain, depression, and a central tremor of upper extremities. The injured worker's past medical treatment includes surgery, physical therapy, and medication therapy. Medications consist of Norco 2.5 one to 2 tablets per day, Ultram ER 150 mg 1 tablet daily, Neurontin 600 mg half a tablet 3 times a day, and Norflex ER 100 mg 1 tablet 2 times a day. An MRI of the right knee obtained on 05/24/2011, revealed extensive tear involving the posterior and anterior horns of the lateral meniscus, extensive bone marrow edema and underlying signal abnormalities suggestive of possible development of osteochondral lesion. It also revealed possible underlying impaction fracture deformity, popliteal bursitis. There was a 5 x 3.2 cm popliteal cyst in medial knee compartment. The injured worker underwent right knee arthroscopy on 07/25/2011. The injured worker complained of chronic pain in the neck, mid back and lower back with pain extending into the tops of the right and left shoulders, as well as extending down the right and left legs. The injured worker rated his pain at a 6-7/10. The injured worker stated that his pain levels were decreased with medication. Physical examination dated 07/02/2014 revealed that the injured worker's right knee had decreased range of motion secondary to pain. There was positive crepitus with range of motion. There was diffuse tenderness about the knee. Physical examination of the thoracic spine revealed tenderness without paraspinal muscle spasm. There was some decreased range of motion of the lumbar spine secondary to pain. There was positive lumbar tenderness and paraspinal muscle spasm. Sensation was intact in all dermatomes of the lower extremities. Reflexes were hypoactive in the knees and ankles, bilaterally symmetric. Babinski sign was absent. No evidence of clonus. The

current treatment plan was for the injured worker to attend 6 sessions of group cognitive behavioral therapy, 6 medication management sessions, and have a sleep study done. The rationale and Request for Authorization form were not submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

6 Sessions of Group CBT- Cognitive behavioral therapy (1 a week for 6 weeks) (6): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Behavioral interventions Page(s): 23. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Cognitive Behavioral Therapy (CBT) guidelines for chronic pain.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic pain programs Page(s): 30-32.

Decision rationale: The request for 6 Sessions of Group CBT- Cognitive behavioral therapy (1 a week for 6 weeks) (6) is not medically necessary. According to California Medical Treatment Utilization Schedule (MTUS) there appears to be little scientific evidence for the effectiveness of multidisciplinary bio-psychosocial rehabilitation compared with other rehabilitation facilities for neck and shoulder pain, as opposed to low back pain and generalized pain syndromes. Given that it is unclear as to whether the injured worker has undergone any psychological treatment and there was no documentation to support as to how the injured worker would benefit from 6 sessions of group cognitive behavioral therapy, the request is not medically necessary.

6 Medication Management Sessions: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Medications for chronic pain.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Behavioral interventions Page(s): 22.

Decision rationale: The request for 6 Medication Management Sessions is not medically necessary. The California Medical Treatment Utilization Schedule (MTUS) guidelines state the identification and reinforcement coping skills is often more useful in the treatment of pain than ongoing medication or therapy, which could lead to psychological or physical dependence. MTUS guidelines recommend an initial trial of 3-4 psychotherapy visits over 2 weeks. The requested submitted is for 6 sessions. The request did not specify over what amount of time, not meeting the MTUS criteria guidelines of over 2 weeks. Furthermore, there was a lack of documentation as to whether the injured worker has or would benefit from psychotherapy. As such, the request for 6 medication management sessions is not medically necessary.

Sleep 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) Polysomnography (sleep studies).

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

Decision rationale: The request for a Sleep Study is not medically necessary. According to the ODG, Polysomnography is only recommended if there is 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. Insomnia is primarily diagnosed clinically with a detailed medical, psychiatric, and sleep history. Polysomnography is indicated when a sleep-related breathing disorder or periodic limb movement disorder is suspected, initial diagnosis is uncertain, treatment fails, or precipitous arousals occur with violent or injurious behavior. However, Polysomnography is not indicated for the routine evaluation of transient insomnia, chronic insomnia, or insomnia associated with psychiatric disorders. A sleep study for the sole complaint of snoring, without one of the above mentioned symptoms, is not recommended. The submitted report lacked any evidence of 6 months complaint of insomnia with at least 4 nights a week. There also lacked quantified evidence of the injured worker having been unresponsive to behavior intervention and sedatives/sleep promoting medications. Given that the injured worker's insomnia complaints are ascribed to chronic pain and depression and are being treated accordingly and in consideration of all the above, based on the on the evidence-based guidelines, the medical necessity for a sleep study is not medically necessary.