

Case Number:	CM14-0059246		
Date Assigned:	07/09/2014	Date of Injury:	06/30/2010
Decision Date:	09/05/2014	UR Denial Date:	04/03/2014
Priority:	Standard	Application Received:	04/29/2014

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 68 year-old male with date of injury 06/30/2010. The medical document associated with the request for authorization, a primary treating physician's progress report, dated 03/27/2014, lists subjective complaints as neck pain, right shoulder, wrist, knee, and ankle pain, and loss of sleep as a result of pain. Objective findings: Examination of the cervical spine revealed decreased range of motion due to pain, spasm, and tenderness of the paravertebral muscles. Examination of the right shoulder revealed decreased range of motion and tenderness to palpation of the acromioclavicular joint and anterior shoulder. Supraspinatus test was positive. Range of motion was restricted and painful in the right wrist, with tenderness and positive Phalen's test. Examination of the right knee and ankle revealed tenderness t palpation and restricted range of motion due to pain. Diagnosis: 1. Cervical myospasm 2. Cervical radiculopathy 3. Cervical strain/sprain 4. Right shoulder impingement syndrome 5. Right shoulder strain/sprain 6. Status post-surgery, right shoulder 7. Right carpal strain/sprain 8. Right carpal tunnel syndrome 9. Right knee internal derangement 10. Right knee strain/sprain 11. Status post-surgery, right knee 12. Right ankle internal derangement 13. Right ankle strain/sprain 14. Loss of sleep 15. Sleep disturbance 16. Anxiety 17. Depression 18. Irritability 19. Nervousness 20. Psych diagnosis 21 elevated blood pressures 22. Hypertension.

IMR ISSUES, DECISIONS AND RATIONALES

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

Overnight Sleep Study: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): 108. Decision based on Non-MTUS Citation Official Disability Guidelines: Polysomnography: In-lab polysomnograms/ 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 (Chronic), Polysomnography.

Decision rationale: According to the Official Disability Guidelines, in-lab polysomnogram / 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. The medical record fails to document any of the above signs or symptoms which cannot be ascribed to one of the patient's numerous diagnoses.