MAXIMUS Federal Services

Case Number:	CM15-0006834		
Date Assigned:	01/23/2015	Date of Injury:	10/04/2010
Decision Date:	03/11/2015	UR Denial Date:	01/02/2015
Priority:	Standard	Application Received:	01/13/2015

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: California
Certification(s)/Specialty: Preventive Medicine, Occupational Medicine

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 sustained an industrial injury on 10/04/2010. He has reported lumbar spine pain, abdominal pain, hypertension, anxiety, depression, and insomnia. The diagnoses have included chronic lumbar spine pain; status post percutaneous drainage, secondary to perforated bowel; and irritable bowel syndrome. Treatment to date has included medications, epidural steroid injections, and surgical interventions. Medications have included amlodipine, benazepril, Gaviscon, and Aciphex. Surgical intervention has included an anterior lumbar interbody fusion at L4-L5 and L5-S1, performed on 07/21/2014. A progress noted from the treating physician, dated 11/18/2014, documented a follow-up visit with the injured worker. The injured worker reported lumbar pain with radiation to the toes, right lower quadrant pain, right hip pain and clicking, and difficulty with sleep. Objective findings included tenderness of the right upper and lower abdominal quadrants. The treatment plan has included medications; fasting labs (GI profile); diagnostic sleep study, and follow-up evaluation. On 01/02/2015 Utilization Review noncertified a Diagnostic Sleep Study. The Official Disability Guidelines: Pain Chapter, Polysomnography, was cited. On 01/06/2015, the injured worker submitted an application for IMR for review of a Diagnostic Sleep Study.

IMR ISSUES, DECISIONS AND RATIONALES

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

Diagnostic 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, Pain Chapter, Polysomnography and Insomnia Treatment

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Pain

Decision rationale: MTUS Guidelines do not address this request. ODG Guidelines address this request in detail and they have very specific criteria that should be met prior to this testing. This criteria includes at least 6 months of insomnia that has been unccessfuly treated with medications and cognative therapy for insomnia. In addition, there more unusual criteria which address faily acute mental status changes. None of these qualifying conditions are documented and there are no unusual circumstances that appear to justify an exception to Guidleines. The request for the Diagnostic Sleep Study is not consistent with Guidelines and is not medically necessary.