

Case Number:	CM15-0180830		
Date Assigned:	09/22/2015	Date of Injury:	06/27/2014
Decision Date:	10/30/2015	UR Denial Date:	09/11/2015
Priority:	Standard	Application Received:	09/14/2015

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, Indiana, New York
 Certification(s)/Specialty: Internal 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 62 year old female, who sustained an industrial-work injury on 6-27-14. She reported initial complaints of left knee pain. The injured worker was diagnosed as having right knee internal derangement with meniscus tearing from compensatory injury and status post left knee arthroscopy with improvement. Treatment to date has included medication, surgery (left knee arthroscopy with debridement), and physical therapy. MRI results were reported on 8- 8-14 that revealed complex tear posterior horn medial meniscus at the meniscotibial attachment root to the free edge body medial meniscus anterior horn medial meniscus with anteriomedial probable parameniscal cyst formation and grade 1 medial collateral strain with medial compartment degenerative change including diffuse chondral thinning osseous edema, grossly intact anterior cruciate ligament, patellofemoral degenerative change with patellar chondral thinning. Currently, the injured worker complains of left knee pain that improved after arthroscopic debridement but she still has discomfort and presently in physical therapy. The right knee is having discomfort due to compensatory injury. Per the primary physician's progress report (PR-2) on 9-8-15, exam of the right knee show tenderness, positive McMurray sign, full range of motion, not gross ligament instability. The left knee exam is within normal limits with well healed anterior incisions. On 8-27-15, the injured worker complained of waking up 2-3 times per night due to bilateral lower extremity cramping. She denies cramping while walking. Diagnosis was venous insufficiency. Current plan of care includes follow up care for right knee, continue physical therapy, and medication. The Request for Authorization requested service to include Sleep Screen Administered # 1. The Utilization Review on 9-11-15 denied the request

due to lack of documentation that described unusual sleep problems, per ODG (Official Disability Guidelines), Chronic Pain.

IMR ISSUES, DECISIONS AND RATIONALES

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

Sleep Screen Administered # 1: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Chronic Pain.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Introduction.

Decision rationale: Pursuant to the Chronic Pain Medical Treatment Guidelines, sleep screen administered #1 is not medically necessary. Thorough history taking is always important in the clinical assessment and treatment planning for the patient with chronic pain and includes a review of medical records. Clinical recovery may be dependent on identifying and addressing previously unknown or undocumented medical or psychosocial issues. A thorough physical examination is also important to establish/confirm diagnoses and observe/understand pain behavior. The history and physical examination serves to establish reassurance and patient confidence. Diagnostic studies should be ordered in this context and community is not simply for screening purposes. In this case, the year the injured worker's working diagnoses are status post left knee arthroscopy; status post partial meniscectomy; chondroplasty; and right knee strain due to compensation. Date of injury is June 27, 2014. Request for authorization is August 27, 2015. According to an August 27, 2015 progress, the subjective complaints include that time at 11 PM, onset sleep within 30 minutes, 2 to 3 times per night the injured worker awakens secondary to like cramping with relief with cyclobenzaprine. There is no clinical rationale for a sleep screen (a questionnaire) in the medical record. There are no subjective symptoms of obstructive sleep apnea or other sleep related difficulties. Based on the clinical information in the medical record, peer-reviewed evidence-based guidelines and no clinical indication a rationale for a sleep screen (questionnaire), sleep screen administered #1 is not medically necessary.