MAXIMUS Federal Services

Case Number:	CM15-0181796		
Date Assigned:	10/14/2015	Date of Injury:	05/11/2009
Decision Date:	12/02/2015	UR Denial Date:	08/17/2015
Priority:	Standard	Application Received:	09/15/2015

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: Physical Medicine & Rehabilitation

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 41 year old female, who sustained an industrial injury on 05-11-2009. She has reported injury to the left knee pain. The diagnoses have included left knee pain, status post arthroscopic surgery, on 06-07-2012; GERD (gastroesophageal reflux disease) and dyspepsia with pylorospasm; irritable bowel syndrome, mixed type with severe constipation component; gastroparesis; hemorrhoids; and sleep disorder insomnia with excessive daytime sleepiness. Treatment to date has included medications, diagnostics, acupuncture, physical therapy, and surgical intervention. Medications have included Tylenol, Advil, Pantoprazole, Metoclopramide; Hyoscyamine, and Ranitidine. A progress note from the treating physician, dated 07-16-2015, documented an evaluation with the injured worker. The injured worker reported that she was doing better regarding her upper and lower gastrointestinal tract signs and symptoms until about two months ago on the medication; she has not been under the care of a primary care provider and she ran out of her medications; she reports a "lump in throat", severe constipation, and right upper quadrant localized abdominal pain; she states that she has developed a prolapsed uterus due to constantly straining at stool; acid reflux is severe especially nocturnally and there is a constant burning epigastric pain; there is nausea and bloating; the left knee is still very painful; and she is unable to sleep. Objective findings included moderate epigastric and left lower quadrant tenderness to palpation; there is localized tenderness just superior to the umbilicus, but along the lateral right rectus muscle; and the abdomen is soft with diminished bowel sounds. The treatment plan has included the request for one abdominal CT (Computed Tomography) scan for hernia; and one overnight polysomnography with multiple

sleep latency testing (MSLT) on following day. The original utilization review, dated 08-17-2015, non-certified the request for one abdominal CT scan for hernia; and one overnight polysomnography with multiple sleep latency testing (MSLT) on following day.

IMR ISSUES, DECISIONS AND RATIONALES

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

One abdominal CT scan for hernia: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation the clearing house.

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

Decision rationale: The patient presents with upper burning central abdominal pain with periodic severe sharp/cramping pain, and left knee pain. Patient has trouble sleeping, as there is a great deal of excessive daytime sleepiness. The request is for one abdominal CT scan for hernia. The request for authorization is not provided. The patient is status post arthroscopic surgery left knee, 06/07/12. MRI of the left knee, 02/26/10, shows no MR evidence of acute internal derangement is identified. Radionuclide bone imaging of the bilateral knees, 09/08/11, shows mild nonspecific increased uptake in the left patella. Patient's diagnoses include GERD and dyspepsia with pylorospasm, uncontrolled; left knee pain; irritable bowel syndrome, mixed type, with severe constipation; gastroparesis; hemorrhoids. Physical examination reveals the abdomen was soft. There was slight to moderate epigastric tenderness to palpation and slight lower quadrant tenderness to palpation. No organ enlargement or masses were detected. Patient's medications include Ranitidine, Riopan, Acetaminophen, and Propranolol. Per progress report dated 07/16/15, the patient is working full-time. ODG Guidelines, Hernia Chapter, under Imaging Section states: "Not recommended except in unusual situations." Imaging techniques such as: MRI, CT scan, and ultrasound are unnecessary except in unusual situations. (Treatment Planning) Ultrasound (US) can accurately diagnose groin hernias and this may justify its use in assessment of occult hernias. In experienced hands US is currently the imaging modality of choice when necessary for groin hernias and abdominal wall hernias. Postoperative complications may also be evaluated. Computerized tomography (CT) may have a place, particularly with large complex abdominal wall hernias in the obese patient. These hernias often contain loops of air-filled bowel, which preclude adequate penetration of the sound beam by US. Clinically obvious hernias do not need ultrasound confirmation, but surgeons may request ultrasound for confirmation or exclusion of questionable hernias or for evaluation of the asymptomatic side to detect clinically occult hernias. If positive, this allows bilateral hernia repair at a single operation. Per progress report dated 07/16/15, treater's reason for the request is "for hernia." Most recent progress reports were handwritten and difficult to read. In this case, the patient continues with abdominal pain. Review of provided medical reports shows no evidence of a prior Abdominal CT Scan. However, guidelines do not recommend the use of imaging such as CT scan for hernia except for unusual situations. Treater does not discuss or document any postoperative complications or the patient to be obese, for which a CT scan would be indicated. Therefore, the request is not medically necessary.

One overnight polysomnograhy with multiple sleep latency testing (MSLT) on following day: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Mental Illness & Stress Chapter under Polysomnography.

Decision rationale: The patient presents with upper burning central abdominal pain with periodic severe sharp/cramping pain, and left knee pain. Patient has trouble sleeping, as there is a great deal of excessive daytime sleepiness. The request is for one overnight polysomnograhy with multiple sleep latency testing (MSLT) on following day. The request for authorization is not provided. The patient is status post arthroscopic surgery left knee, 06/07/12. MRI of the left knee, 02/26/10, shows no MR evidence of acute internal derangement is identified. Radionuclide bone imaging of the bilateral knees, 09/08/11, shows mild nonspecific increased uptake in the left patella. Patient's diagnoses include GERD and dyspepsia with pylorospasm, uncontrolled; left knee pain; irritable bowel syndrome, mixed type, with severe constipation; gastroparesis; hemorrhoids. Physical examination reveals the abdomen was soft. There was slight to moderate epigastric tenderness to palpation and slight lower quadrant tenderness to palpation. No organ enlargement or masses were detected. Patient's medications include Ranitidine, Riopan, Acetaminophen, and Propranolol. Per progress report dated 07/16/15, the patient is working full-time. ODG Guidelines, Mental Illness & Stress Chapter under Polysomnography Section states: "Recommended after at least 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." Criteria for Polysomnography: Polysomnograms / 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) Sleep-related breathing disorder or periodic limb movement disorder is suspected; (7) 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; (8) Unattended (unsupervised) home sleep studies for adult patients are appropriate with a home sleep study device with a minimum of 4 recording channels (including oxygen saturation, respiratory movement, airflow, and EKG or heart rate). Treater does not discuss the request. In this case, treater has documented the patient's complaint of excessive daytime sleepiness, which is a guideline criterion for a Polysomnography. However, the treater does not document the duration of the patient's insomnia complaint. ODG guidelines require at least six months of an insomnia complaint. Furthermore, psychiatric etiology has not been excluded in this patient's complaint, which is also required. Therefore, the request is not medically necessary.