MAXIMUS Federal Services

Case Number:	CM15-0098030		
Date Assigned:	05/29/2015	Date of Injury:	04/01/2008
Decision Date:	09/15/2015	UR Denial Date:	05/01/2015
Priority:	Standard	Application Received:	05/21/2015

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: Texas, Florida, 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 70 year old female, who sustained an industrial injury on 4/1/08. She reported bilateral foot pain. The injured worker was diagnosed as having reported sleep disturbance, reported depression and anxiety, rule out left peroneal neuropathy, status post left knee arthroscopy x2, rule out residual left knee internal derangement, status post right cuneiform fusion, residual right foot internal derangement, status post left cuneiform fusion, and residual left foot internal derangement. Treatment to date has included trigger point injections, Synvisc injections, acupuncture, physical therapy, a home exercise program, and medication. The injured worker also had counseling and biofeedback. Currently, the injured worker complains of pain in the left knee and bilateral feet. Anxiety, depression and sleep disturbance were also noted. The treating physician requested authorization for a psychological consultation, a sleep study, a pain management consultation, and a neurological consultation.

IMR ISSUES, DECISIONS AND RATIONALES

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

Psychological consultation: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Psychological treatment.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) Chapter 7, page 127.

Decision rationale: This claimant was injured in 2008, now 7 years ago with sleep disturbance, reported depression and anxiety, rule out left peroneal neuropathy, status post left knee arthroscopy x2, rule out residual left knee internal derangement, status post right cuneiform fusion, residual right foot internal derangement, status post left cuneiform fusion, and residual left foot internal derangement. Treatment to date has included trigger point injections, Synvisc injections, acupuncture, physical therapy, a home exercise program, and medication. The injured worker also had counseling and biofeedback. There is continued pain. ACOEM Guidelines, Chapter 7, Page 127, state that the occupational health practitioner may refer to other specialists if a diagnosis is uncertain or extremely complex, when psychosocial factors are present, or when the plan or course of care may benefit from additional expertise. A referral may be for consultation to aid in the diagnosis, prognosis, therapeutic management, determination of medical stability, and permanent residual loss and/or the examinee's fitness for return to work. A consultant is usually asked to act in an advisory capacity, but may sometimes take full responsibility for investigation and/or treatment of an examinee or patient. The patient has had previous psychological counseling; the objective functional improvement out of the last intervention is unknown. This request for the repeat psychological consult fails to specify the concerns to be addressed in the independent or expert assessment, including the relevant medical and non-medical issues, diagnosis, causal relationship, prognosis, temporary or permanent impairment, work capability, clinical management, and treatment options. At present, the request 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.

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

Decision rationale: This claimant was injured in 2008, now 7 years ago with sleep disturbance, reported depression and anxiety, rule out left peroneal neuropathy, status post left knee arthroscopy x2, rule out residual left knee internal derangement, status post right cuneiform fusion, residual right foot internal derangement, status post left cuneiform fusion, and residual left foot internal derangement. Treatment to date has included trigger point injections, Synvisc injections, acupuncture, physical therapy, a home exercise program, and medication. The injured worker also had counseling and biofeedback. There is continued pain. The MTUS is silent on sleep studies. The ODG notes regarding sleep studies that they are 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. The claimant meets none of these criteria. Further In-lab

polysomnograms / sleep studies are recommended for the combination of indications listed below: (1) Excessive daytime somnolence. This criterion is not met. (2) Cataplexy (muscular weakness usually brought on by excitement or emotion, virtually unique to narcolepsy); This criterion is not met. (3) Morning headache (other causes have been ruled out); this criterion is not met. (4) Intellectual deterioration (sudden, without suspicion of organic dementia); This criterion is not met. (5) Personality change (not secondary to medication, cerebral mass or known psychiatric problems); this criterion also is not met. (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. Again, this criterion is not met. Therefore, the request was appropriately not medically necessary under the evidence-based criteria.

Pain Management Consultation: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) Chapter 7, page 127.

Decision rationale: This claimant was injured in 2008, now 7 years ago with sleep disturbance, reported depression and anxiety, rule out left peroneal neuropathy, status post left knee arthroscopy x2, rule out residual left knee internal derangement, status post right cuneiform fusion, residual right foot internal derangement, status post left cuneiform fusion, and residual left foot internal derangement. Treatment to date has included trigger point injections, Synvisc injections, acupuncture, physical therapy, a home exercise program, and medication. The injured worker also had counseling and biofeedback. There is continued pain. ACOEM Guidelines, Chapter 7, Page 127, state that the occupational health practitioner may refer to other specialists if a diagnosis is uncertain or extremely complex, when psychosocial factors are present, or when the plan or course of care may benefit from additional expertise. A referral may be for consultation to aid in the diagnosis, prognosis, therapeutic management, determination of medical stability, and permanent residual loss and/or the examinee's fitness for return to work. A consultant is usually asked to act in an advisory capacity, but may sometimes take full responsibility for investigation and/or treatment of an examinee or patient. It appears that many pain management interventions have failed. This request for the consult fails to specify the concerns to be addressed in the independent or expert assessment, including the relevant medical and non-medical issues, diagnosis, causal relationship, prognosis, temporary or permanent impairment, work capability, clinical management, and treatment options. At present, the request is not medically necessary.

Neurological consultation: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) Chapter 7, page 127.

Decision rationale: As shared previously, this claimant was injured in 2008, now 7 years ago with sleep disturbance, reported depression and anxiety, rule out left peroneal neuropathy, status post left knee arthroscopy x2, rule out residual left knee internal derangement, status post right cuneiform fusion, residual right foot internal derangement, status post left cuneiform fusion, and residual left foot internal derangement. Treatment to date has included trigger point injections, Synvisc injections, acupuncture, physical therapy, a home exercise program, and medication. The injured worker also had counseling and biofeedback. There is continued pain. Again, the ACOEM Guidelines, Chapter 7, Page 127, state that the occupational health practitioner may refer to other specialists if a diagnosis is uncertain or extremely complex, when psychosocial factors are present, or when the plan or course of care may benefit from additional expertise. A referral may be for consultation to aid in the diagnosis, prognosis, therapeutic management, determination of medical stability, and permanent residual loss and/or the examinee's fitness for return to work. A consultant is usually asked to act in an advisory capacity, but may sometimes take full responsibility for investigation and/or treatment of an examinee or patient. There are unclear neurologic issues, and lack of clarify as to why a neurologist is needed for musculoskeletal injury. This request for the consult fails to specify the concerns to be addressed in the independent or expert assessment, including the relevant medical and non-medical issues, diagnosis, causal relationship, prognosis, temporary or permanent impairment, work capability, clinical management, and treatment options. At present, the request is not medically necessary.