

Case Number:	CM13-0003817		
Date Assigned:	12/27/2013	Date of Injury:	06/01/2007
Decision Date:	02/07/2014	UR Denial Date:	07/16/2013
Priority:	Standard	Application Received:	07/26/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Internal Medicine and is licensed to practice in New York. 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 physician 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:

The patient is a 46 year old male with hypertension treated with Diovan in 01/25/2013. He also had depression treated with fluoxetine and seroquel. On 01/25/2013 he was 6 feet tall and weighed 268 pounds. The BMI was 36.35 (morbid obesity is a BMI of 40 or greater). Blood pressure was 140/90. He was alert. Neurologic exam was normal. Judgment, insight, thought content and abstract reasoning were intact. On 05/03/2013 he denied fatigue. He weighed 269 pounds. The O2 saturation on room air was 99%. He was alert. Blood pressure was 120/80. He was referred for an overnight oximetry but there was no reason provided for the test. It does say sleep apnea after this notation. On 05/23/2013 he had an overnight oximetry. The mean O2 saturation was 94.2%. Range was 99% to 78%. A desaturation event was defined as a decrease of 4% or more in O2 saturation. During 8 hours of monitoring - there were 217 desaturation events less than 3 minutes and an additional 9 events longer than 3 minutes. This averages out to 28.25 desaturation events per hour. The request is for a diagnostic polysomnogram with a CPAP titration as needed (split night study).

IMR ISSUES, DECISIONS AND RATIONALES

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

Diagnostic Polysomnogram and CPAP Titration split night sleep study RX: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter, Criteria for Polysomnography.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Kryger MH, Roth T, Dement WC. Principles and Practice of Sleep Medicine, 5th Edition 2011.

Decision rationale: There are no good published guidelines for when to order a polysomnogram to diagnose or rule out sleep apnea. The reference used in the previous review denial was taken from ODG Chronic Pain section and indicated that if the patient had insomnia for several months perhaps it was from sleep apnea and not just pain and perhaps a polysomnogram is indicated. Actually in clinical sleep medicine practice sleep onset insomnia is not an indication of a sleep study since patients with sleep apnea typically have a decreased sleep latency. This patient does not have chronic pain and most patients with obstructive sleep apnea (OSA) have no pain. Thus, the practice guideline from ODG chronic pain section is not appropriate. The practice Guidelines of the American Academy of Sleep Medicine do not address this point. What is addressed by Medicare and the American Academy of Sleep Medicine is the criteria of when CPAP is indicated using the results of the polysomnogram. However, there is no published guideline of when to order a polysomnogram to diagnose sleep apnea that is a standard of care. The above referenced textbook is "a bible of sleep medicine." From this textbook and my experience reviewing over 5,000 sleep medicine cases it is clear that a polysomnogram is indicated when there is a high clinical suspicion of sleep apnea as it is the only method used to diagnose that condition. The typical clinical risk factors for a patient with OSA is obesity (BMI of 35 or greater), daytime hypersomnia (hopefully the provider used the Epworth Sleep score), awakening choking or gasping, witnessed apnea during sleep, if not obese then an abnormal oropharynx anatomy; however there is no true guideline and all patients with a high risk must be tested as the diagnosis can not be made without the polysomnogram. In this case, I don't think it is fair to penalize the patient because he was not evaluated by a sleep medicine specialist since the patient is obese, has hypertension and most importantly has the features of multiple apneas/hypopnea as demonstrated in the overnight oximetry. During the polysomnogram an apnea is defined as no inspiration for at least 10 seconds. A hypopnea is defined as a decrease in inspiration of at least 30% accompanied with a decrease in the O₂ saturation of at least 4%. The measurement of the total apneas and hypopneas per hour - apnea hypopnea index (AHI) is the most important measurement for the diagnosis and necessity of treatment for OSA. Normal AHI is 0 - 5. The usual criteria for the medical necessity for treatment with CPAP is an AHI of 15 or greater. For this patient with hypertension it is an AHI of 5 or greater. Thus, this patient has a lower threshold for needing treatment. None of the clinical factors were sought as this patient was not evaluated by a sleep medicine specialist but the results of the oximetry using definitions for hypopnea of a decrease in O₂ saturation of at least 4% indicated that the AHI would be over 25. Non