

Case Number:	CM13-0024494		
Date Assigned:	06/11/2014	Date of Injury:	12/04/2011
Decision Date:	08/07/2014	UR Denial Date:	08/15/2013
Priority:	Standard	Application Received:	09/16/2013

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. The expert reviewer is Board Certified in Physical Medicine & Rehabilitation and is licensed to practice in California. 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/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 injured worker is a 54-year-old female with a reported date of injury on 12/04/2011. The mechanism of injury was noted to be due to cumulative trauma. Her diagnoses were noted to include carpal tunnel syndrome, cervical myofasciitis, and cervical intervertebral disc displacement. Her previous treatments were noted to include shock wave treatments, group therapy, chiropractic care, ice, heat, and a wrist brace. The progress note dated 07/09/2013 revealed the injured worker complained of constant cervical and bilateral upper extremity pain. The cervical complaints were described as limited to the mid and lower cervical regions, while the upper extremity complaints were inclusive of the bilateral elbows, wrists, and hands. The intensity of her complaint of symptoms continued to vary between 5/10 - 8/10. The injured worker reported ongoing difficulty falling to sleep and remaining asleep due to her symptoms. The physical examination revealed cervical musculature to be hypertonic; however, there were no spasms, swelling, or asymmetric loss of motion noted. The injured worker continued to describe pain upon firm digital palpation of the cervical spine regions. The motion palpation of the cervical region of the spine revealed decreased movement of the C5-7 vertebral motion units. The deep tendon reflexes in the upper extremities were bilaterally diminished at 1+/4 in response. The upper extremity sensory evaluation incorporated a standard pinwheel and revealed subjective descriptions of hypoesthesia in the right C6-7 dermatomal regions. Strength in the upper extremities was reduced with complaints of pain, at best estimate was rated 3/5. The request for authorization form was not submitted within the medical records. The request is for a multiple sleep latency test and a diagnostic sleep study. However, the provider's rationale was not submitted within the medical records.

IMR ISSUES, DECISIONS AND RATIONALES

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

MULTIPLE SLEEP LATENCY TEST: 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 Official Disability Guidelines (ODG), Pain, Polysomnography.

Decision rationale: The request for a multiple sleep latency test is not medically necessary. The injured worker complained she had been waking up due to her pain. The Official Disability Guidelines recommend after at least 6 months of insomnia complaint (at least 4 nights a week), unresponsive to behavior intervention and sedative/sleep promoting medications, and after psychiatric etiology has been excluded. The guidelines do not recommend polysomnography for the routine evaluation of transient insomnia, chronic insomnia, or insomnia associated with psychiatric disorders. The guidelines criteria for polysomnography is recommended for the combination of indications such as excessive daytime somnolence, cataplexy, morning headache, intellectual deterioration, personality change, sleep related breathing disorder, or periodic limb movement disorder is suspected, and insomnia complaint for at least 6 months, 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 recommended. There is a lack of documentation regarding excessive daytime somnolence, cataplexy, morning headache, intellectual deterioration, personality change, or insomnia for at least 6 months. Additionally, there is not a recent, complete, adequate assessment submitted within the medical records. Therefore, the request for Multiple Sleep Latency Test is not medically necessary.

DIAGNOSTIC SLEEP STUDY: 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 Official Disability Guidelines (ODG), Pain, Polysomnography.

Decision rationale: The request for a diagnostic sleep study is not medically necessary . The injured worker complained she had been waking up due to her pain. The Official Disability Guidelines recommend after at least 6 months of insomnia complaint (at least 4 nights a week), unresponsive to behavior intervention and sedative/sleep promoting medications, and after psychiatric etiology has been excluded. The guidelines do not recommend polysomnography for the routine evaluation of transient insomnia, chronic insomnia, or insomnia associated with psychiatric disorders. The guidelines criteria for polysomnography is recommended for the combination of indications such as excessive daytime somnolence, cataplexy, morning headache,

intellectual deterioration, personality change, sleep related breathing disorder, or periodic limb movement disorder is suspected, and insomnia complaint for at least 6 months, 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 recommended. There is a lack of documentation regarding excessive daytime somnolence, cataplexy, morning headache, intellectual deterioration, personality change, or insomnia for at least 6 months. There is not a recent, complete, adequate assessment submitted within the medical records. Therefore, the request for Diagnostic Sleep Study is not medically necessary.