

Case Number:	CM13-0065027		
Date Assigned:	01/03/2014	Date of Injury:	05/18/2013
Decision Date:	04/11/2014	UR Denial Date:	11/27/2013
Priority:	Standard	Application Received:	12/12/2013

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 Preventive Medicine, has a subspecialty in Occupational and Environmental Medicine 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 expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records: The patient is a 31 year old male who was injured on 05/18/2013 while he was attacked by a co-worker, punching his face and chest, eye and deviating his nasal septum. He suffers posttraumatic middle ear disturbance since his injury. He complains since then of dizziness, tinnitus, vertigo and disequilibrium. Diagnostic studies reviewed include MRI of the right shoulder dated 07/22/2013 documenting mild degenerative changes of the acromioclavicular joint with joint space narrowing, subchondral edema and minimal joint effusion as well as subacromial bursitis. PR-2 dated 11/27/2013 documented the patient to have complaints of increased nasal congestion, dizziness, chest pain, right upper extremity pain with numbness and decreased range of motion, headaches, vertigo, disequilibrium, and irritability, nose pain and congestion along with jaw pain. Objective findings on exam included positive Barany Hallpike, Mallampati 4, tenderness to palpation, slurred speech, dysarthria, over bite, TMJ tenderness to palpation bilateral. Diagnoses: 1. Posttraumatic lower back pain, rule out S1 radiculopathy. 2. Posttraumatic right shoulder dislocation, rule out brachial plexus. 3. Posttraumatic middle ear trauma. 4. Posttraumatic TMJ pain. 5. Posttraumatic facial and nasal fracture, rule out OSA.

IMR ISSUES, DECISIONS AND RATIONALES

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

POLYSOMNOGRAM STUDY TO RULE OUT OBSTRUCTIVE SLEEP APNEA (OSA):

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), Pain-Polysomnography

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) 2009, Chapter 4 Pain-Polysomnography

Decision rationale: MTUS does not specifically address of poly sonogram/sleep study, therefore the Official Disability Guidelines (ODG) were referenced. According to the ODG, sleep studies are recommended for the combination of indications as listed: 1) Excessive daytime somnolence. 2) Cataplex. 3) Morning headache. 4) Intellectual deterioration. 5) Personality change. 6) Insomnia complaint for At least six months unresponsive to behavior intervention and sedative/sleep-promoting medications and psychiatric etiology has been excluded. Based on the clinical information submitted, there is no documentation to show the patient has excessive daytime somnolence, Cataplex, morning headache (complaints of headaches were documented but not morning episodes), insomnia complaints for at least 6 months. The patient stated during a 07/03/2013 neuro evaluation he cannot sleep at night but this was secondary to louder snoring. A sleep study for the sole complaint of snoring, without one of the above-mentioned symptoms, is not recommended. The medical file does not document an injury consistent with the above criteria. Therefore, the medical file does not support a polysomnogram study as medically necessary.