

Case Number:	CM14-0106331		
Date Assigned:	07/30/2014	Date of Injury:	09/14/2011
Decision Date:	10/01/2014	UR Denial Date:	07/01/2014
Priority:	Standard	Application Received:	07/09/2014

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 Occupational 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:

Injured worker is a male with date of injury 9/14/2011. Per neurology progress note dated 4/30/2014, the injured worker follows up for traumatic brain injury (TBI) with secondary epilepsy, frontal lobe syndrome, aggravation of migraine headaches and chronic cerebrospinal fluid leak (CSF) leak with one bout of meningitis since his TBI. He is not sleeping as well as he would like. He still tends to awaken at night in spite of continuous positive airway pressure (CPAP). He has no trouble falling asleep, but awakens with an average of every 1 hour. After he awakens he can generally go back to sleep, sometimes after he goes to the bathroom. He does not feel there is anything in particular that is weighing on his mind. He does not awaken refreshed but will get more alert as the day goes on. He does take Flexeril at bedtime for his bruxisms, but this is not everyday. Neurological examination noted that facial sensation was decreased over the left face. Facial strength testing showed right central facial. Air conduction was greater than bone conduction on the right. Air conduction was less than bone conduction on the left. There was lateralization of the sound of a tuning fork to the left. Muscle tone was increased on the right more than the left. RAMs were slowed on the left. Gait and station were wide based and not antalgic. He was fluent, but had occasional word finding problems. He was slow and indecisive in responses and made frequent qualifications to his answers. Diagnoses include 1) TBI 2) post traumatic epilepsy 3) chronic CSF leak with history of one bout of meningitis 4) OSA aggravated by TBI 5) depression 6) right shoulder disruption and chronic pain 7) aggravation of chronic migraine headaches 8) low back pain 9) hypertension 10) hypovitaminosis B12 and D 11) neurogenic bladder and erectile dysfunction from TBI 12) headache pain over craniotomy area 13) insomnia related to depression vs pain vs nocturia vs PMLS 14) hypogonadism secondary to AED and opiate use.

IMR ISSUES, DECISIONS AND RATIONALES

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

Polysomnogram: Upheld

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

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

Decision rationale: The California Medical Treatment Utilization Schedule (MTUS) Guidelines do not address the use of sleep evaluation. The Official Disability Guidelines (ODG) recommends the use of polysonogram 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. Other indications include excessive daytime somnolence, cataplexy, morning headache (other causes have been ruled out), intellectual deterioration, personality change, sleep-related breathing disorder or periodic limb movement disorder is suspected. The injured worker is already using a CPAP, but wakes frequently with the ability to fall asleep and does not awaken feeling refreshed. The requesting physician is requesting a repeat polysomnography to determine if CPAP settings need to be changed. The claims administrator recommends that the injured worker be evaluated by a sleep specialist to determine if a repeat sleep study is indicated. This is a very reasonable recommendation as the clinical evaluation and history alone do not establish medical necessity for this request within the recommendations of the ODG. The request for Polysomnogram is determined to not be medically necessary.