

Case Number:	CM14-0118087		
Date Assigned:	08/06/2014	Date of Injury:	01/11/2010
Decision Date:	09/22/2014	UR Denial Date:	07/18/2014
Priority:	Standard	Application Received:	07/28/2014

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 Anesthesiology, has a subspecialty in Pain Management, and is licensed to practice in Tennessee. 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:

This is a 48-year-old female with a 1/11/10 date of injury. The exact mechanism of injury has not been described. On 4/22/14, the patient was noted to have sleep hygiene difficulties. Her physician recommended Sonata, but the patient is taking it irregularly and has an irregular pattern of her sleep cycle. She was counseled on sleep hygiene techniques. On 6/26/14, the patient presented with back and neck pain of 8/10. Her most significant difficulty is falling asleep. It was suggested she take melatonin, but she denies any benefit from the melatonin. She recalls sleepwalking while taking Ambien. She denies being told she snores or has episodes of breathing cessation. She has tried Remeron and trazodone without benefit. She states she has difficulty falling asleep, and her sleep is very broken up, where she will only sleep for 10-30 minutes to 2 hours at a time. Her venlafaxine ER dose will be increased. On 6/19/14, it was noted that the patient is currently undergoing treatment with CBT and is making progress, but still has ongoing anxiety and depression, which is interfering with her ability to function. Objective exam: no anxiety, confusion, fatigue, lethargy. She uses a cane and wheelchair in the office. Diagnostic Impression: Depression, Insomnia. Treatment to date: medication management, psychotherapy, TENS unit, aqua therapy, CBT. A UR decision dated 7/18/14 denied the request for sleep study because it is noted that a psychiatric etiology is present, and the patient is currently undergoing psychotherapy. She is also not taking Sonata as prescribed, therefore the records do not establish that she is unresponsive to sedative/sleep promoting medications. In addition, it is noted that the patient does not exhibit fatigue, confusion, or lethargy.

IMR ISSUES, DECISIONS AND RATIONALES

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

Testing: Sleep Study: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines. Decision based on Non-MTUS Citation ODG: Pain Chapter: Criteria for Polysomnography; Pain Chapter: Insomnia Treatment.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Pain Chapter: Sleep Study.

Decision rationale: CA MTUS does not address this issue. ODG criteria for polysomnography include: Excessive daytime somnolence; Cataplexy; Morning headache; Intellectual deterioration; Personality change; & 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. In addition, a sleep study for the sole complaint of snoring, without one of the above-mentioned symptoms, is not recommended. However, there is no documentation that the patient is exhibiting excessive daytime somnolence, cataplexy, morning headaches, intellectual deterioration or personality changes. In fact, she is documented to not exhibit any evidence of fatigue, anxiety, confusion, or lethargy. In addition, the patient is not documented to have failed behavioral intervention, and is currently undergoing psychotherapy with CBT and has noted improvement of her symptoms. Furthermore, the patient has not failed sedative medications and is noted to take Sonata irregularly and is not compliant with her prescribed medications. The guidelines only support sleep studies if the patient is unresponsive to behavior intervention, sedative/sleep-promoting medications, and a psychiatric etiology of the patient's insomnia has not been excluded. Therefore, the request for Testing: Sleep Study was not medically necessary.