

Case Number:	CM14-0139163		
Date Assigned:	09/10/2014	Date of Injury:	06/18/2009
Decision Date:	10/06/2014	UR Denial Date:	08/07/2014
Priority:	Standard	Application Received:	08/28/2014

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 Physical Medicine & Rehabilitation and is licensed to practice in Texas. 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:

Medical records reflect the claimant is a 47 year old male who sustained a work injury on 6-18-09 to the left knee and back. On this date, the claimant slipped after missing the last stop of the stairs. Documentation reflects the claimant sustained a right Achilles tendon rupture on 4-5-14 when he was on an elliptical exercising machine. The claimant is status post repair of Achilles tendon rupture performed on 4-9-14. Office visit on 7-9-14 notes the claimant is in a cast boot. He states that his right knee gave out when he sustained an Achilles tendon rupture. He continues to have moderate pain in the right knee at 8/10. The medial and lateral aspect of his right knee is worse with prolonged standing and ambulation, He has moderate synovitis of the right knee. His left knee still has mild to moderate synovitis which is worse with prolonged standing and ambulation. Physical examination of the bilateral knees reveals mild to moderate effusion of the right knee. Right knee range of motion is from 5 to 125 degrees of flexion with pain along the posterior horn and mid-zone of the medial and lateral meniscus. The left knee has mild effusion with focal tenderness along the medial compartment. Left knee range of motion is from 5 to 130 degrees of flexion with negative McMurray at the end of the terminal flexion, MRI of the right knee shows a degenerative medial meniscus tear of the right nerve posterior horn, a horizontal cleavage tear of the posterior horn and medial meniscus, and a complex tear of the lateral meniscus, with degenerative arthritis of both the patellofemoral joint graded as moderate medial compartment arthritis. The patient is depressed and has difficulty dealing with long term limitation of both knees. He also has sleep issues due to pain. Diagnosis include bilateral knee bicompartament osteoarthritis, right knee internal derangement with posterior horn and medial meniscus and mid zone and posterior horn and lateral meniscus tear, as well as bicompartamental osteoarthritis of his right knee, status post video arthroscopy of his left knee, arthroscopic medial and lateral meniscectomy and chondroplasty of medial compartment.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 consultation for sleep studies: 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)

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

Decision rationale: ODG reflects that polysomnography is recommended 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. Not recommended for the routine evaluation of transient insomnia, chronic insomnia, or insomnia associated with psychiatric disorders. Home portable monitor testing may be an option. A polysomnogram measures bodily functions during sleep, including brain waves, heart rate, nasal and oral breathing, sleep position, and levels of oxygen saturation. It is administered by a sleep specialist, a physician who is Board eligible or certified by the American Board of Sleep Medicine, or a pulmonologist or neurologist whose practice comprises at least 25% of sleep medicine. (Schneider-Helmert, 2003) According to page 3-17 of the AMA Guides (5th ed), sleep disorder claims must be supported by formal studies in a sleep laboratory. (Andersson, 2000) However, home portable monitor testing is increasingly being used to diagnose patients with obstructive sleep apnea (OSA) and to initiate them on continuous positive airway pressure (CPAP) treatment, and the latest evidence indicates that functional outcome and treatment adherence in patients evaluated according to a home testing algorithm is not clinically inferior to that in patients receiving standard in-laboratory polysomnography. (Kuna, 2011) Insomnia is primarily diagnosed clinically with a detailed medical, psychiatric, and sleep history. Polysomnography is indicated when a sleep-related breathing disorder or periodic limb movement disorder is suspected, initial diagnosis is uncertain, treatment fails, or precipitous arousals occur with violent or injurious behavior. However, polysomnography is not indicated for the routine evaluation of transient insomnia, chronic insomnia, or insomnia associated with psychiatric disorders. (Littner, 2003) Criteria for Polysomnography: Polysomnograms / sleep studies are recommended for the combination of indications listed below: (1) Excessive daytime somnolence; (2) Cataplexy (muscular weakness usually brought on by excitement or emotion, virtually unique to narcolepsy); (3) Morning headache (other causes have been ruled out); (4) Intellectual deterioration (sudden, without suspicion of organic dementia); (5) Personality change (not secondary to medication, cerebral mass or known psychiatric problems); (6) Sleep-related breathing disorder or periodic limb movement disorder is suspected; & (7) 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. A sleep study for the sole complaint of snoring, without one of the above mentioned symptoms, is not recommended. There is an absence in documentation noting that this claimant has been unresponsive to behavior intervention and sedative/sleep-promoting medications, and after

psychiatric etiology has been excluded. A sleep study is not recommended for the routine evaluation of transient insomnia, chronic insomnia, or insomnia associated with psychiatric disorders. It is noted that this claimant has psychological issues dealing with his limitations. There is an absence in documentation noting his sleep habits. Therefore, the medical necessity for consultation for sleep studies is not medically established, as other diagnoses have not been excluded. The request is not medically necessary.

