

<b>Case Number:</b>	CM14-0156499		
<b>Date Assigned:</b>	09/26/2014	<b>Date of Injury:</b>	11/29/2011
<b>Decision Date:</b>	11/12/2014	<b>UR Denial Date:</b>	08/27/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/24/2014

### 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 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:

According to the records made available for review, this is a 41-year-old female with an 11/29/11 date of injury. At the time (7/22/14) of request for authorization for Diagnostic Sleep Study, there is documentation of subjective (chest pain when anxious, nape pain radiating to the front of the head, and sleep disturbances due to ongoing orthopedic pain and anxiety) and objective (diffuse tenderness to palpitation throughout the abdomen) findings, current diagnoses (gastritis, gastroesophageal reflux disease secondary to medications, constipation secondary to irritable bowel syndrome, history of sleep dysfunction, and adjustment disorder with mixed anxiety and depressed mood), and treatment to date (medications). There is no documentation of excessive daytime somnolence; cataplexy (muscular weakness usually brought on by excitement or emotion, virtually unique to narcolepsy); morning headache (other causes have been ruled out); intellectual deterioration (sudden, without suspicion of organic dementia); personality change (not secondary to medication, cerebral mass or known psychiatric problems); sleep-related breathing disorder or periodic limb movement disorder is suspected; and/or 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.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Diagnostic Sleep Study:** Upheld

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

**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:** California Medical Treatment Utilization Schedule (MTUS) does not address this issue. Official Disability Guidelines (ODG) identifies documentation of excessive daytime somnolence; cataplexy (muscular weakness usually brought on by excitement or emotion, virtually unique to narcolepsy); morning headache (other causes have been ruled out); intellectual deterioration (sudden, without suspicion of organic dementia); personality change (not secondary to medication, cerebral mass or known psychiatric problems); sleep-related breathing disorder or periodic limb movement disorder is suspected; and/or 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, as criteria necessary to support the medical necessity of polysomnography. Within the medical information available for review, there is documentation of diagnoses of gastritis, gastroesophageal reflux disease secondary to medications, constipation secondary to irritable bowel syndrome, and history of sleep dysfunction. However, despite documentation of a diagnosis of history of sleep dysfunction, there is no (clear) documentation of excessive daytime somnolence; cataplexy (muscular weakness usually brought on by excitement or emotion, virtually unique to narcolepsy); morning headache (other causes have been ruled out); intellectual deterioration (sudden, without suspicion of organic dementia); personality change (not secondary to medication, cerebral mass or known psychiatric problems); sleep-related breathing disorder or periodic limb movement disorder is suspected; and/or 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. Therefore, based on guidelines and a review of the evidence, the request for Diagnostic Sleep Study is not medically necessary.