

<b>Case Number:</b>	CM14-0037854		
<b>Date Assigned:</b>	06/25/2014	<b>Date of Injury:</b>	02/28/2009
<b>Decision Date:</b>	07/29/2014	<b>UR Denial Date:</b>	03/06/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/31/2014

### 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 , has a subspecialty in Surgical Critical Care, 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:

The injured worker is a 61-year-old who was injured on February 28, 2009. MRI of the right shoulder dated March 17, 2009 showed possible tendinosis involving the distal supraspinatus tendon, abnormal signal in superior labrum and associated paralabral cyst compatible with SLAP tear and mild osteoarthritis involving the glenohumeral joint and acromioclavicular (AC) joint arthropathy. MRI left shoulder dated March 17, 2009 showed abnormal signal in the superior labrum possibly representing tear and acromioclavicular joint arthropathy and suggestion of mild impingement. Electrodiagnostic (EMG/NCV) study of upper extremities dated April 16, 2009 showed mild bilateral ulnar nerve injury at the wrist. On April 20, 2010 ultrasound of the bilateral wrist and elbow was normal. Ultrasound of the knees dated April 20, 2010 showed bilateral medial joint line narrowing, left medial meniscus (evidence of meniscectomy/no new tear found) and right medial meniscus mucoid/myxoid degeneration (no communication with any surface). Ultrasound of shoulders dated April 20, 2010 showed status post right shoulder arthroscopy, right subacromial fibrosis/adhesions, status post Mumford procedure on the right and left shoulder comparison (narrowing of subacromial space/rotator cuff tendinitis with articular surface fraying/AC joint bone spur/osteophyte). MRI of the hips dated April 20, 2010 showed mild bilateral osteoarthritis. The patient reported injury to his knees, upper extremities, neck, hips and bilateral shoulders. Prior treatment included knee surgery and postoperative PT (physical therapy), right shoulder injection, right shoulder arthroscopy and postoperative PT and eye surgeries. The request for polysomnogram was denied on January 14, 2014 as there were no recent medical reports for the requesting physician and no assessment of the patient's current sleep pattern disturbances, documentation of failure of appropriate attempts at conservative care and sleep hygiene or co-morbidities. On February 13, 2014 the patient complained of poor sleep. He reported that he was always a mild snorer and during the time he was working as an active

firefighter, he would have mild snoring, but never loud enough to disrupt his fellow firefighters' sleep. He reported that his wife has reported that he has more snoring now than he used to in the past. Even after his retirement, he felt that he often slept with one eye open and would wake up in the night dreaming that he is still on active duty. The diagnoses were chronic insomnia and doubt obstructive sleep apnea (OSA). The recommended treatment was polysomnography followed by a Multiple Sleep Latency Test (MSLT). According to the utilization review dated March 6, 2014 the request for sleep study and MSLT was denied as there was no indication that the patient had tried any sleep medications to address the sleeping problems. Without documentation of failed initial care, proceeding with a sleep study and MSLT was not indicated.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

#### **Polysomnogram: Overturned**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) - TWC Pain Procedure Summary.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (Chronic), Polysomnography Other Medical Treatment Guideline or Medical Evidence: Clinical guideline for the evaluation, management and long-term care of obstructive sleep apnea in adults. Epstein LJ, Kristo D, Strollo PJ Jr, Friedman N, Malhotra A, Patil SP, Ramar K, Rogers R, Schwab RJ, Weaver EM, Weinstein MD; Adult Obstructive Sleep Apnea Task Force of the American Academy of Sleep Medicine. J Clin Sleep Med. 2009 Jun 15;5(3):263-76.

**Decision rationale:** The claimant has been referred to a pulmonologist and a comprehensive sleep history has been obtained. There is a request for polysomnography to rule out Obstructive Sleep Apnea (OSA). The records show that this is reasonable given the sleep history. The request for a polysomnography is medically necessary and appropriate.

#### **MSLT 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 (ODG) -TWC Pain Procedure.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Clinical guideline for the evaluation, management and long-term care of obstructive sleep apnea in adults. Epstein LJ, Kristo D, Strollo PJ Jr, Friedman N, Malhotra A, Patil SP, Ramar K, Rogers R, Schwab RJ, Weaver EM, Weinstein MD; Adult Obstructive Sleep Apnea Task Force of the American Academy of Sleep Medicine. J Clin Sleep Med. 2009 Jun 15;5(3):263-76. Aetna Clinical Policy Bulletin: Multiple Sleep Latency Test (MSLT) Number: 0330 [http://www.aetna.com/cpb/medical/data/300\\_399/0330.html](http://www.aetna.com/cpb/medical/data/300_399/0330.html).

**Decision rationale:** The claimant appears to have sleep disturbance. The history is suggestive of Obstructive Sleep Apnea (OSA) such that Polysomnography has been requested. There is also a request for Multiple Sleep Latency Test (MSLT). MSLT is useful in the evaluation of narcolepsy but is generally considered experimental for all other indications. (See Aetna Clinical Practice Bulletin) MSLT is not routinely indicated for the evaluation and diagnosis of OSA or its subsequent treatment. (See Epstein, LJ; et.al. J of Clinical Sleep Medicine) There is no discussion of narcolepsy in the notes available for review. The history and signs and symptoms are more in line with OSA. Should Polysomnography prove the claimant does not have OSA, then MSLT can be reconsidered if narcolepsy comes in the differential. The request for MSLT study is not medically necessary or appropriate.