

<b>Case Number:</b>	CM14-0068116		
<b>Date Assigned:</b>	07/14/2014	<b>Date of Injury:</b>	01/03/2014
<b>Decision Date:</b>	10/08/2014	<b>UR Denial Date:</b>	05/06/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/13/2014

### 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 Internal 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:

The injured worker is a 57 year old male who was reported to have an industrial injury on January 3, 2014. He was evaluated on 1/13/2014 and noted to have cervical strain, head injury NOS and left shoulder pain. He was prescribed naproxen 500 mg as directed. He was seen again on 2/3/2014 and noted to have post-concussion symptoms including fatigue and difficulty getting up and having energy. Physical therapy was prescribed. He was seen by Neurologist on 2/12/2014 and 2/26/2014 with findings of post-concussion syndrome with decreased concentration, memory problems, fatigue, poor sleep and facial numbness on the left, with non physiologic tremors at times. MRI brain, CT head and neck and EEG were reportedly normal. He was prescribed trazodone and depakote but reportedly had been unable to take these due to side effects. He had dizziness and tinnitus for which appropriate consultation with audiologist and ENT specialist had been certified. The patient did have physical therapy performed. Speech therapy was also pursued since he reported speech problems and involuntary movements. The neurologist was noted to have opined that no further neurological evaluation and management was necessary but that psychiatric treatment and evaluation should be sought. This was documented in the 4/14/2014 report of the primary treating provider. He was seen by primary treating provider on 4/29/2014 wherein sleep hygiene was discussed and outpatient pulmonology consultation was sought for sleep study due to prolonged insomnia post-concussion/ post injury.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Outpatient sleep study with pulmonologist:** 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 Chapter, Ppolysomnography

**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

**Decision rationale:** Per the applicable guidelines, polysomnography is recommended when a psychiatric etiology and organic etiology have been ruled out and insomnia persists for six months or so, approximately four nights a week, and is unresponsive to appropriate sleep hygiene measures as well as short term use of pharmacologic agents such as sedatives. As the patient had a concussion and developed a post concussion syndrome with a variety of complaints some of which have abated, and a psychiatric etiology for his insomnia has not been ruled out and the patient has not maintained therapy with sedatives, a polysomnogram is unlikely to yield the diagnosis. His complaints do not appear to stem from a sleep related breathing disorder, and he does not have cataplexy, morning headache, excessive daytime somnolence or periodic limb movement disorder. His EEG was normal, as was the MRI of the brain. There is no documented snoring, increased neck girth or snorting, or early morning headaches. Indeed, the most likely diagnosis is a post concussion insomnia. The provider has failed to document appropriate details of sleep hygiene and it is not clear that an appropriate and sustained effort has been made toward educating the patient about the importance of using a sedative at a small dose that may afford the patient some relief. Only over the counter melatonin and zolpidem were prescribed but no effort was made to modulate the dose and try alternative agents when the patient reported intolerance. Given the aforementioned factors, the request for polysomnogram is not medically necessary at this time, is not supported by applicable guidelines and is not recommended CA MTUS and ACOEM guidelines do not address request for polysomnography. So alternative guidelines were used.