

Case Number:	CM14-0096029		
Date Assigned:	07/25/2014	Date of Injury:	02/06/2011
Decision Date:	11/24/2014	UR Denial Date:	05/27/2014
Priority:	Standard	Application Received:	06/24/2014

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 Preventive Medicine, has a subspecialty in Occupational Medicine and Public Health & General Preventive Med, and is licensed to practice in Iowa, Illinois and Hawaii. 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 patient is a 31 year old employee with date of injury of 2/6/2011. Medical records indicate the patient is undergoing treatment for s/p lumbar fusion at L3 through S1 with instrument fixation; cervical myoligamentous sprain and strain; depression and anxiety secondary to industrial injury; GI complaints and low vitamin D level. He has major depressive disorder, single episode and sleep disorder due to pain and depression. Subjective complaints include low back pain does intensify with PT. He reports his low back pain radiates into the right lower extremity and up to the cervical spine. He is reporting benefit from seeing a pain psychologist. He has headaches on a daily basis and migraine headaches one or two times per week. Objective findings include continued tenderness and limited range of motion (ROM) in the cervical spine. His low back is tender and he has a reduction of ROM. He is limited and apprehensive during the exam. He appears depressed. He says he is exhausted, feels more sadness and has more crying spells, has trouble remembering and has an inability to relax. A CT of the lumbar spine with contrast (3/21/2014) showed postsurgical changes, bilateral degenerative facet hypertrophy at L2-L3, mild posterior osteophytes at L3-L4 and L4-L5 and right L5-S1 neuroforaminal narrowing. Treatment has consisted of PT, Magnesium glycinate 800 g with vitamin D3 5000 IU; Exalgo; MSIR; Clonazepam; Maxalt; Zanaflex; Omeprazole; Mirtazapine (discontinued); Bupropion XL; Clonidine and Klonopin. The utilization review determination was rendered on 6/24/2014 recommending non-certification of a Polysomnogram.

IMR ISSUES, DECISIONS AND RATIONALES

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

Polysomnogram: Upheld

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

Decision rationale: MTUS is silent regarding sleep apnea studies. ODG states "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) 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." While the treating physician did document difficulty sleeping, the treating physician did not document excessive daytime somnolence, cataplexy, morning headaches, intellectual deterioration, and suspicion of organic dementia, sleep breathing disorder, or periodic limb movements. The patient is diagnosed with major depressive disorder and sleep disorder due to pain and depression. In addition the treating physician did not document that sleep disturbance due to psychiatric etiology had been ruled out and provide evidence of sleep apnea screening with an Epworths sleep scale. As such, the request for Polysomnogram is not medically necessary.