

Case Number:	CM14-0193951		
Date Assigned:	12/01/2014	Date of Injury:	02/23/2006
Decision Date:	01/16/2015	UR Denial Date:	10/23/2014
Priority:	Standard	Application Received:	11/19/2014

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 Family 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:

This 57-year-old teacher's aide reported a right knee and hip injury after she fainted and fell during a meeting with her supervisors on 2/23/06, which she interpreted as hostile and stressful. Her past medical history was notable for left leg weakness due to removal of cancerous muscle (myosarcoma) and for the need to walk with a cane. She had a right knee arthroplasty and subsequently developed fibroarthrosis. She has ongoing knee pain followed by an orthopedist, with diagnoses of joint pain and osteoarthrosis. She is also followed by a psychologist with supervision from a psychiatrist for diagnoses of depressive disorder not otherwise specified, and sleep disorder. The records contain a report from a complex psychiatric and psychological re-evaluation performed 3/28/14. It states that the patient has difficulty staying asleep, and that once she awakens she has difficulty getting back to sleep. She awakens once per night, and sleeps 6-9-hours per night. There are multiple notes in the records from the psychologist dated from 8/18/13 to 8/8/14. Most of them briefly describe the patient as having trouble falling and staying asleep. The 8/8/14 note states that sometimes the patient wakes up with a panic attack in the middle of the night, which is associated with shortness of breath and difficulty breathing. The 10/22/14 UR report refers to an exam report of 1/3/14 and requests for authorization dated 1/20/14 and 6/11/14 from an internist. There is also a reference to "clinical data" from 9/17/14. These reports, requests and data are not contained in the available records. According to the UR report, the 9/17/14 data describes a patient who awakens to void and then has difficulty returning to sleep. The patient has a number of allergies and some difficulty with breathing through the nose as she attempts to fall asleep. Apparently the internist, whose records are not available to me, generated a request for a sleep study. I am therefore unable to determine what her rationale for ordering the study was. The study was non-certified in UR on 10/22/14 on the basis of lack of criteria for a sleep study according to an article on insomnia in the Annals of Internal Medicine and to an

article on polysomnography in Clinics in Chest Medicine. The records contain a report of a sleep study that was performed on 9/16/14, which was apparently retroactively non-certified on 10/22/14. The patient's current medications include hydrocodone/APAP 10/325, orphenadrine ER, diclofenac ER, pantoprazole ER, and clonidine. She has not worked since her date of injury, 3/23/06.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retroactive Sleep Study (DOS: 09/16/2014): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Wilson JF. In the clinic. Insomnia. Annals of Internal Medicine 2008;148(1):ITC13-1-ITC13-16 and Jafari B, Mohsenin V. Polysomnography. Clinics in Chest Medicine 2010;31(2):287-97

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: Sleep studies are also referred to as polysomnograms. According to the ODG reference above, polysomnography is not recommended for the routine evaluation of transient insomnia, chronic insomnia, or insomnia associated with psychiatric disorders. Polysomnography is recommended for the combination of indications listed below: 1) Excessive daytime somnolence; 2) Cataplexy (muscular weakness brought on by excitement or emotion, and virtually unique to narcolepsy); 3) Morning headache, after 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. 8) Unattended (unsupervised) home sleep studies for adult patients are appropriate with a home sleep study device with a minimum of 4 recording channels (including oxygen saturation, respiratory movement, airflow and EKG or heart rate). The available clinical documentation does not support the performance of a sleep study in this case. Although it is clear that the patient has had complaints of sleep difficulties for over six months, it is not clear that problems occur at least 4 nights per week. None of the records documents a careful assessment of her sleep difficulties. One of the notes states that she awakens once per night and gets 6-9 hours of sleep per night, which would suggest that she might not even have insomnia. A psychiatric etiology has not been excluded (At least one note documents that she awakens due to panic attacks). There is no record of interventions of any kind, including behavioral intervention or sedative/hypnotic prescription. There is no documentation of concern for excessive daytime somnolence, catalepsy, morning headaches, intellectual deterioration, sleep-related breathing disorder, or limb movement disorder. In addition, if one of these conditions had been a concern, a more appropriate study would have been an unattended home

sleep study, and not the more elaborate (and expensive) sleep lab-based polysomnogram, which was performed on 9/16/14. Based on the evidence-based citation above and on the clinical documentation in this case, a sleep study is not medically necessary. It is not medically necessary because no appropriate evaluation of the patient's sleep difficulties is documented, because the etiology of her sleep problems is unclear and may be psychological, because no behavioral or pharmacologic interventions were performed, and because no concern was documented for any of the conditions described above that would be an indication for a sleep study.