MAXIMUS Federal Services

Case Number:	CM14-0021120		
Date Assigned:	05/07/2014	Date of Injury:	09/14/2011
Decision Date:	03/06/2015	UR Denial Date:	01/27/2014
Priority:	Standard	Application Received:	02/20/2014

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
State(s) of Licensure: Florida, New York, Pennsylvania
Certification(s)/Specialty: Family Practice

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 48 age year old male, who sustained an industrial injury on September 14, 2011. He has reported headaches once or twice a week, does not feel refreshed after a night's sleep, his jaw locks up and has to relax maximally so as to relive this. The diagnoses have included traumatic brain injury with left posterior temporal lobe contusion, left subarachnoid hemorrhage and left temporal fracture, status post neurosurgical decompression with frontotemporal parietal craniectomy and subsequent flap replacement, posttraumatic cerebral spinal fluid leak (CSF), episode of bacterial meningitis secondary to CSF leak, dental injuries with TMJ dysfunction, cervical strain with myofascial pain, thoracolumosacral strain, antecedent headaches aggravated by traumatic brain injury, obstructive sleep apnea, probably aggravated by the head injury, posttraumatic dizziness, orthopedic injuries including right wrist fracture, right rib fracture, scapular fracture and no with adhesive capsulitis treated conservatively and posttraumatic seizures. Treatment to date has included CPAP, Toradol, Midrin, Effexor, and Xanax. Currently, the IW complains of headaches and complaints of not feeling rested after a night's sleep.Prior to the accident the injured worker used CPAP with benefit; he did not experience daytime sleepiness prior to the injury.On January 27, 2014 Utilization Review non-certified CPAP titration, noting the ODG and http://www.ncbi.nlm.nih.gov/pubmed/17449396 was cited.On January 17, 2014 IMR application was received, the injured worker submitted an application for IMR for review of CPAP titration.

IMR ISSUES, DECISIONS AND RATIONALES

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

CPAP Titration: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Pain (updated 01/07/14) Polysomnography

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Polysomnography at www.MayoClinic.org/tests-procedures/polysomnography Obstructive Sleep Apnea Treatment and Management at emedicine.medscape.com/article/295807 The Approach to patients with daytime sleepiness after treatment with CPAP

Decision rationale: MTUS does not specifically address the role of CPAP, Polysomnography and the diagnosis of OSA. However the member sustained serious trauma resulting in TBI with frontal lobe syndrome and a reported exacerbation of pre-existing OSA for which the member had been using CPAP. The member was reported to be tired, moody, experiencing headaches, a non-restorative sleep as well as falling asleep at work. He also was waking up after 1 to 2 hours of sleep at night but reportedly could get back to sleep. If the member continued to fall asleep at work there was every expectation that the member would lose his job per his PTP. The request was made to repeat the polysomnography to evaluate the impact of the TBI and be certain of the primary diagnosis of OSA as well as to rule out other diagnoses such as Narcolepsy, Periodic Limb Movement Disorder or other non-OSA related sleep disorders. In the interim the member was prescribed Dexedrine to help with the daytime hypersomnolence in an effort to improve his daytime functioning. This presented risks based on the members seizure disorder and potential for interaction with the already large number of prescribed medications. The member's wife reported that he was using the CPAP consistently. The issue of the adequacy of titration was not addressed and could be adequately identified with another sleep study. The specific impact of the TBI on his OSA does not seem to have been explicitly evaluated and a repeat polysomnogram could be compared to the original study see what exactly the role of the TBI had been. Assessing the adequacy of the current titration and assessing the potential to improve the quality and restorative nature of his sleep with CPAP could avoid further complications from the addition of another medication as well as the threat to his employability. I believe that a repeat polysomnogram would provide important useful information and should have been approved. I NON-CONCUR with the UR decision to not certify this request.