

<b>Case Number:</b>	CM14-0086883		
<b>Date Assigned:</b>	07/23/2014	<b>Date of Injury:</b>	09/12/2004
<b>Decision Date:</b>	05/04/2015	<b>UR Denial Date:</b>	05/22/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/09/2014

### 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: California, Arizona, Maryland  
Certification(s)/Specialty: Psychiatry

### 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 year old female, who sustained an industrial injury on 09/12/2004. She has reported subsequent back pain and was diagnosed with lumbosacral spondylosis and disc degeneration. The injured worker was also diagnosed with major depression and panic disorder with agoraphobia. Treatment to date has included oral pain medication. In a progress note dated 04/12/2014, the injured worker complained of continued back pain. Objective findings were notable for a severe limp and impaired attention, concentration and short term memory. The physician noted that the injured worker reported continued insufficient restorative sleep which was most likely a consequence of obstructive sleep apnea. A request for authorization of polysomnography with CPAP was made.

### IMR ISSUES, DECISIONS AND RATIONALES

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

#### **Follow-up Polysomnography with CPAP: 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), Treatment Index, 11th Edition (Web), 2013, Pain , Polysomnography.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chronic Pain Polysomnography.

**Decision rationale:** Per ODG "Polysomnography: Recommended after at least six months of an insomnia complaint (at least four nights a week), unresponsive to behavior intervention and sedative/sleep-promoting medications, and after psychiatric etiology has been excluded. Not recommended for the routine evaluation of transient insomnia, chronic insomnia, or insomnia associated with psychiatric disorders. Home portable monitor testing may be an option. A polysomnogram measures bodily functions during sleep, including brain waves, heart rate, nasal and oral breathing, sleep position, and levels of oxygen saturation. It is administered by a sleep specialist, a physician who is Board eligible or certified by the American Board of Sleep Medicine, or a pulmonologist or neurologist whose practice comprises at least 25% of sleep medicine. (Schneider-Helmert, 2003) According to page 3-17 of the AMA Guides (5th ed), sleep disorder claims must be supported by formal studies in a sleep laboratory. (Andersson, 2000) However, home portable monitor testing is increasingly being used to diagnose patients with obstructive sleep apnea (OSA) and to initiate them on continuous positive airway pressure (CPAP) treatment, and the latest evidence indicates that functional outcome and treatment adherence in patients evaluated according to a home testing algorithm is not clinically inferior to that in patients receiving standard in-laboratory polysomnography. (Kuna, 2011) Insomnia is primarily diagnosed clinically with a detailed medical, psychiatric, and sleep history. Polysomnography is indicated when a sleep-related breathing disorder or periodic limb movement disorder is suspected, initial diagnosis is uncertain, treatment fails, or precipitous arousals occur with violent or injurious behavior. However, polysomnography is not indicated for the routine evaluation of transient insomnia, chronic insomnia, or insomnia associated with psychiatric disorders. (Littner, 2003) Criteria for Polysomnography: 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) 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)." Guidelines recommend that sleep study is indicated after psychiatric etiology has been excluded and specifically for one of the above mentioned indications. The injured worker has had a Polysomnogram earlier. The request for Follow-up Polysomnography with CPAP is not medically necessary.