

Case Number:	CM14-0097189		
Date Assigned:	07/28/2014	Date of Injury:	02/28/2013
Decision Date:	01/26/2015	UR Denial Date:	06/04/2014
Priority:	Standard	Application Received:	06/25/2014

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 patient is an injured worker with a history of injuries to the head, cervical spine, lumbar spine, bilateral shoulders, bilateral arms, and bilateral lower extremities. Date of injury was February 28, 2013. The initial comprehensive report by consulting physician in Internal Medicine dated May 7, 2014 documented that on February 28, 2013, he sustained injuries to his head, cervical spine, lumbar spine, bilateral shoulders, bilateral arms, and bilateral lower extremities. As he was standing on an eight foot ladder fixing a pipe, the ladder twisted causing the patient to lose his balance and fall backwards. The patient reported the injury and was referred to an industrial clinic for an evaluation and treatment. On June 17, 2013, the patient presented to the orthopedic surgeon for evaluation and treatment. The last time the patient was examined was in April 2014, and the patient noted he developed abdominal pain, acid reflux, alternating diarrhea and constipation, which the patient attributes to the medications prescribed, as well as weight gain of approximately fifty pounds. Medications included Ibuprofen, Omeprazole, and Nabumetone. There is no history of trauma to the head. The patient denies any blurred vision or history of glaucoma. The patient denies any sleep apnea, shortness of breath, dyspnea on exertion, cough, asthma, wheezing, hemoptysis, rhonchi, or bronchitis. There is no history of tuberculosis or chemical exposure. The patient denies any chest pain, hypertension, syncope, malignant arrhythmias, palpitations, coronary artery disease, heart attack, or heart murmur. The patient admits to suffering from abdominal pain, acid reflux, diarrhea, and constipation. The patient also notes weight gain fifty pounds. The patient denies any nausea, vomiting, melena, bright red blood per rectum, peptic ulcer disease, or hepatitis. The patient denies diabetes mellitus, hyperlipidemia, and thyroid disease. The patient admits to suffering from musculoskeletal pain in the cervical spine, bilateral shoulders, bilateral upper extremities, lumbar spine, bilateral lower extremities, and bilateral knees. The patient denies any

fibromyalgia, rheumatoid arthritis, systemic lupus erythematosus, degenerative joint disease or gout. The patient denies any cramps in his calf muscles, claudication, or wounds. There is no history of deep venous thrombosis. The patient admits to suffering from numbness, tingling, weakness, and memory impairment. The patient was diagnosed with Bell's Palsy in 2013. The patient denies any seizures, transient ischemic attack, or cerebrovascular accident. The patient admits to suffering from depression, stress, anxiety, and insomnia. The patient denies easy bruisability and blood dyscrasias. There is no history of anemia. The patient denies drinking alcohol at present or in the past. He does not smoke cigarettes and denies smoking in the past. There is no history of drug abuse. His family medical history is unremarkable. The total Epworth sleepiness scale score is 6. When asked about nighttime sleeping patterns, the patient states he breathes through his mouth while sleeping. The patient states that he snores. The patient complains of awaking four times per night due to pain and stress. With respect to nighttime sleep disturbances, the patient has found himself gasping for air while sleeping. The patient also suffers from stomach acids coming up into his mouth at night. The patient reports depression, nervousness, crying spells, irritability, self-doubt, mood changes, sleeplessness, fatigue, frustration, fear of death or dying, yelling and screaming, problems with family and friends, loss of interest in life, anxiety, helplessness, worry, confused thoughts, poor self-esteem, and loss of interest in usual activities. Physical examination was documented. The patient is alert and oriented, pleasant and cooperative. Pupils are equal, round and reactive to light and accommodation. Extraocular muscles are intact. There is no nystagmus appreciated. There are no icteric sclerae. There is no evidence of effusion or otitis noted. Nasal examination is without any lesions. Throat is clear. There are no exudates or thrush. There is no elevation in the jugular venous pressures. There are 2+ carotid upstrokes. There are no systolic or diastolic bruits noted. There is no lymphadenopathy or thyromegaly. Cardiac examination demonstrated regular rate and rhythm, S1 and S2. There are no rubs or gallops appreciated. The lungs are clear to auscultation. There are no rales or wheezes appreciated. There is no dullness to percussion. No clubbing, cyanosis or edema was noted. No calf tenderness was noted. No tenderness or decreased range of motion of the spine was noted. Cranial nerves II through XII are grossly intact. Diagnoses included abdominal pain, acid reflux, and sleep disorder. Treatment plan was documented. Upon physical examination today, the patient displayed objective findings of epigastric tenderness, consistent with his subjective complaints of abdominal pain, acid reflux, diarrhea and constipation. The patient has possible gastropathy secondary to the use of NSAIDs. Stress and NSAIDs can lead to increased gastric acid production and cause irritation of the mucosal lining of the stomach as well as alteration of bowel function. The patient reports sleep disturbance, waking three to four times per night, and complains of snoring, gasping for air, and stomach acids coming up into her mouth at night. As there is no evidence of pre-existing sleep problems, it is highly likely that this complaint is attributable to pain and stress, both of which are known to significantly impact sleep quality. Therefore, I am referring the patient for a formal sleep study to rule out obstructive sleep apnea on an industrial basis. The patient was advised to follow a course of sleep hygiene. As the patient continues to experience depression, stress, and anxiety as a result of his industrial injury, it was recommended that the primary treating physician refer him to a psychiatric specialist for further evaluation.

IMR ISSUES, DECISIONS AND RATIONALES

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

Sleep study.: 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) Mental Illness & Stress Polysomnography.

Decision rationale: Medical Treatment Utilization Schedule (MTUS) does not address polysomnography. Official Disability Guidelines (ODG) states that polysomnography is 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. Polysomnography is not recommended for the routine evaluation of transient insomnia, chronic insomnia, or insomnia associated with psychiatric disorders. The initial comprehensive report by consulting physician in Internal Medicine dated May 7, 2014 documented that the patient denied any sleep apnea, shortness of breath, dyspnea on exertion, chest pain, hypertension, syncope, arrhythmias, or palpitations on the review of systems. The consultation report noted that there was no evidence of pre-existing sleep problems. The consultant expressed the opinion that the patient's sleep complaint was attributable to pain and stress, both of which are known to significantly impact sleep quality. The patient was experiencing depression, stress, and anxiety as a result of his industrial injury, and psychiatric specialist referral was recommended. The total Epworth sleepiness scale score was 6 which is normal. Excessive daytime somnolence was not documented. Cataplexy was not documented. Past behavior intervention was not documented. A trial and response to sedative sleep-promoting medications were not documented. The patient denied any sleep apnea. The Epworth sleepiness scale score was normal. Psychiatric problems were noted. The sleep complaints were attributed to pain and a psychiatric etiology according to the consultation report. Per ODG, polysomnography is not recommended for the routine evaluation of transient insomnia, chronic insomnia, or insomnia associated with psychiatric disorders. The request for polysomnography sleep study is not supported by the medical records and Official Disability Guidelines (ODG) Therefore, the request for Sleep study is not medically necessary.