MAXIMUS Federal Services

Case Number:	CM15-0191945		
Date Assigned:	10/06/2015	Date of Injury:	06/11/2014
Decision Date:	11/18/2015	UR Denial Date:	09/03/2015
Priority:	Standard	Application Received:	09/29/2015

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
Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 was a 41 year old male, who sustained an industrial injury, June 11, 2014. The injured worker was undergoing treatment for cervicalgia, cervical sprain and or strain, cervicogenic headaches, contusion to the face, neck and scalp, contusion of the head and sleep disturbances and poor cooping. According to progress note of August 24, 2015, the injured worker's chief complaint was pain around the neck region with stiffness. The injured worker had minimal radicular pain. The injured worker was also having headaches without nausea or vomiting or photo sensitivity. The injured worker was having difficulty with staying asleep. The injured worker continued to work full time. According to the physical exam the injured workers Epworth sleep scale was rated at 5, which was within normal limits according to the progress note. The injured worker previously received the following treatments cervical MRI showed mild arthropathy at multiple levels with mild foraminal narrowing at C5-C6. The injured worker was taking Naproxen for the headaches, Omeprazole, TENS (transcutaneous electrical nerve stimulator) unit, LidoPro ointment, Cyclobenzaprine, home exercise program, chiropractic therapy and acupuncture. The RFA (request for authorization) dated August 24, 2015, the following treatments were requested an in house sleep hygiene. The UR (utilization review board) denied certification on September 3, 2015; for the retrospective service of in house sleep hygiene, date of service August 24, 2015.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective In-house sleep hygiene (DOS 8/24/15): 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), Pain Chapter, 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 (chronic) chapter under Polysomnography.

Decision rationale: The 41 year old patient complains of pain and stiffness in the neck, rated at 5/10, along with minimal radicular pain and photo sensitivity, as per progress report dated 08/24/15. The request is for RETROSPECTIVE IN-HOUSE SLEEP HYGIENE (DOS 8/24/15). The RFA for this case is dated 08/24/15, and the patient's date of injury is 06/11/14. Diagnoses, as per progress report dated 08/24/15, included cervicalgia/neck pain; cervical sprain/strain; cervicogenic headaches; contusion of face, neck and scalp; contusion of head; and sleep disturbance/poor coping. Medications included Naproxen, Omeprazole and Lidopro cream. The patient is working full time, as per the same report. ODG-TWC guidelines, Pain (chronic) chapter under Polysomnography, list the following 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) 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." In this case, the patient has been having sleep issues since 07/19/14, as per sleep survey dated 08/24/15. As per progress report dated, 08/24/15, the patient "has difficulty staying asleep." A sleep hygiene study was performed at the treater's office during the visit, and the patient got an Epworth score of 5. The treater states that although the Epworth scale is within normal limits, the patient does have hard time to staying asleep. He would like to manage his sleep without medication at this moment. Most prior reports document that the patient has difficulty staying asleep and the treater recommends sleep hygiene. In progress report dated 05/06/15, the treater states sleep issue 2-3 X week. As per report dated 04/24/15, "he sleeps 6 hours with interruptions due to the pain or without [without] any reason." The treater has asked for "sleep hygiene" but does not explain what this entails. Sleep hygiene typically is education and counseling regarding sleep management. It is not known why this requires separate billing as it is something that is done during normal office visitation. The request IS NOT medically necessary as a separate service apart from a routine office visitation.