MAXIMUS Federal Services

Case Number:	CM15-0057448		
Date Assigned:	04/02/2015	Date of Injury:	11/09/2011
Decision Date:	05/05/2015	UR Denial Date:	03/11/2015
Priority:	Standard	Application Received:	03/26/2015

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: Iowa, Illinois, Hawaii
Certification(s)/Specialty: Preventive Medicine, Occupational Medicine, Public Health & General Preventive Medicine

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 44-year-old male, who sustained an industrial injury on 11/09/2011. He reported falling off a ladder and hitting his head. The injured worker was diagnosed as having traumatic closed head injury, major depression, single episode, pain disorder, anxiety disorder, cognitive sleep disorder. Treatment to date has included diagnostics, sleep study dated 9/11/2014; sleep study dated 2/05/2015, CNS interdisciplinary rehabilitation program, and medications. The progress note, dated 1/26/2015, noted medications as Celebrex, and Ambien. A previous progress note, dated 12/30/2014, noted medications as Advil, Ambien, Celebrex, Vicodin, Nortriptyline, and Zanaflex. The sleep study report (study date 2/05/2015) noted an impression of obstructive sleep apnea syndrome, mild, and resolved at continuous positive airway pressure of 12cm/H2O. A request for continuous positive airway pressure, with supplies and additional equipment, was submitted.

IMR ISSUES, DECISIONS AND RATIONALES

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

CPAP/BiPAP: 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).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Up-to-date, CPAP and Obstructive Sleep Apnea, http://www.uptodate.com/.

Decision rationale: Up to date summary and recommendations for OSA and CPAP-Obstructive sleep apnea (OSA) is a disorder with serious comorbidities. Continuous positive airway pressure (CPAP) is an effective therapy for OSA, but adherence is suboptimal. (See 'Introduction' above.) CPAP use should be routinely monitored using objective criteria. Self-reported correlates with actual use but routinely overestimates it. (See 'Identification' above.) The absence of proven risk factors for poor adherence has hindered the development of interventions to prevent non-adherence. Until such risk factors are identified, management of the side effects of CPAP therapy and behavioral therapy seem to be the most reasonable approaches to improve adherence (see 'Interventions' above): A multidisciplinary approach to managing side effects related to CPAP therapy has been developed and is illustrated in the figure (algorithm 1). This approach recognizes that most side effects can be corrected by simple interventions. (See 'Side effect management' above.)-Behavioral therapy can improve adherence with CPAP. We suggest that all patients with OSA who are prescribed CPAP receive behavioral therapy (Grade 2B). The consequences of OSA and the beneficial effects of CPAP should be emphasized, especially by frequent contact and follow-up during the first week of treatment. (See 'Behavioral therapy' above.)-There are conflicting data regarding use of sedative-hypnotics at the time of CPAP initiation. Until further data become available, we do not suggest use of a sedative-hypnotic at the time of CPAP initiation (Grade 2B). This is based on the larger effect sizes observed in studies using behavioral therapy and the greater risk of side effects from drug therapy. (See 'Pharmacological therapy' above.)-The pathophysiology of residual sleepiness in adherent (>6 hours use) patients remains unclear. However, some studies have shown that treatment with modafinil or armodafinil improves alertness. (See "Evaluation and management of residual sleepiness in obstructive sleep apnea", section on 'Treatment'.)UPTODATE states concerning sleep apnea treatment "The maximum benefits of positive airway pressure therapy are realized when patients use their devices regularly. CPAP use should be routinely determined using objective criteria and monitored sequentially over time [33]. There are a variety of interventions that can help promote CPAP use, including troubleshooting device side effects and behavioral therapy. (See "Adherence with continuous positive airway pressure (CPAP)".)". The patient had a previous sleep study and was prescribed a CPAP machine in 9/2014 but was not compliant with the machine. The patient continued to have trouble falling asleep and feeling rested. In addition, there is no distinct advantage of BIPAP over CPAP and thus the request for BIPAP is also not medically necessary. It is also not clear if the patient ever picked up the CPAP prescribed in 9/2014 or what happened to that machine. As such, the request for CPAP/BIPAP is not medically necessary.