

Case Number:	CM15-0059693		
Date Assigned:	04/06/2015	Date of Injury:	11/09/2011
Decision Date:	05/05/2015	UR Denial Date:	03/11/2015
Priority:	Standard	Application Received:	03/30/2015

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, Indiana, New York
Certification(s)/Specialty: Internal 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 has reported injury to the head. The diagnoses have included traumatic closed head injury; traumatic brain injury; chronic neck/back pain; and moderate obstructive sleep apnea. Treatment to date has included medications, diagnostic studies, acupuncture, and full-day treatment program. Medications have included Celebrex, Tizanidine, and Ambien. A progress note from the treating provider, dated 01/07/2015, documented a follow-up visit with the injured worker. Currently, the injured worker complains of headache, rated 7/10 on the visual analog scale; still not sleeping well, only a few hours per night; and his neck pain is a little better. Objective findings have included cervical paravertebral muscles are tender touch; left shoulder tenderness to palpation; recall testing at 5 minutes is 0/3; and gait is antalgic. The treatment plan has included the request for Peek sleep study with CPAP (Continuous Positive Airway Pressure) polysomnography.

IMR ISSUES, DECISIONS AND RATIONALES

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

Peek sleep study with CPAP polysomnography: 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/polysomnography, criteria for 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 Section, Polysomnography.

Decision rationale: Pursuant to the Official Disability Guidelines, the sleep study with CPAP polysomnography is not medically necessary. 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. Not recommended for routine evaluation of transient insomnia, chronic insomnia or insomnia associated with psychiatric disorders. The criteria are enumerated in the Official Disability Guidelines. Polysomnography is recommended for the following combination of indications: excessive daytime somnolence; cataplexy; morning headache; intellectual deterioration; personality change; sleep-related breathing disorder; insomnia complaint at least six months (at least four nights a week), etc. The injured worker does not have cataplexy, morning headaches (specifically) with other causes ruled out; intellectual deterioration (some, without suspicion of organic dementia); personality change (not secondary to medication, cerebral mass for known psychiatric problems); sleep-related breathing disorder or periodic limb movement disorder; insomnia complaint for at least six months (at least four nights of the week, unresponsive to behavior intervention and sedative/sleep promoting medications and a psychiatric etiology has been excluded. A sleep study with the sole complaint of snoring is not recommended. In this case, the injured worker's working diagnoses are traumatic closed head injury; chronic neck/back pain; rule out lumbar radiculopathy; left shoulder impingement; depression/anxiety; vitamin D deficiency; and sleep disorder. The most recent progress note in the medical record is dated January 7, 2015. The progress note contains the request for the initial sleep study performed on February 5, 2015. The documentation indicates the injured worker underwent an overnight polysomnography study for the evaluation of a possible sleep disorder on February 5, 2015. The injured worker was noted to have mild obstructive sleep apnea syndrome resolve at CPAP of 12 cm/H₂O. The request for authorization date is March 4, 2015. Subsequent progress notes do not contain a clinical rationale for repeat testing. There is no subsequent documentation after the January 7, 2015 progress note. As a result, there is no clinical indication or rationale for repeating the sleep study. Consequently, absent clinical documentation with a clinical indication or rationale (with subsequent progress notes after January 7, 2015), the sleep study with CPAP polysomnography is not medically necessary.