

Case Number:	CM15-0088046		
Date Assigned:	05/12/2015	Date of Injury:	08/05/2014
Decision Date:	07/03/2015	UR Denial Date:	04/28/2015
Priority:	Standard	Application Received:	05/07/2015

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 (IW) is a 64 year old male who sustained an industrial injury on 08/05/2014. He reported injury in a motor vehicle accident where he sustained neck, back and facial injuries. The injured worker was diagnosed as having nasal fracture, cervical strain with degenerative disc disease, and lumbosacral strain. Treatment to date has included epidural injection, physical therapy, a sleep study with continuous positive airway pressure evaluation, and cognitive-behavioral psychotherapy for coping with his traumatic work injury and associated symptoms. Currently, the injured worker complains of persistent neck, low back and facial pain. On examination, the IW has tenderness at the paracervical and parathoracic region. There is no sign of facial trauma, no ecchymosis, visible swelling or deformity. The nasal laceration is well healed. A CT scan does show fractured nasal bones with a deviated septum. A sleep study was done 04/02/2015 and a diagnosis of obstructive sleep apnea made. The treatment plan includes scheduled appointments with an ENT specialist and a sleep specialist. A request for authorization is made for a CPAP Set up 1 Month Trial Rental with Supplies.

IMR ISSUES, DECISIONS AND RATIONALES

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

CPAP Set Up 1 Month Trial Rental with Supplies RFA Not Dated: Overturned

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 Official Disability Guidelines (ODG) Head, Sleep Aids and Other Medical Treatment Guidelines Uptodate, CPAP and Obstructive Sleep Apnea <http://www.uptodate.com/>.

Decision rationale: MTUS is silent on the use of CPAP. ODG states "Recommended. Sleep disturbance is a relatively common complication following TBI. Common sleep disorders for which individuals are at risk include, but are not limited to, posttraumatic hypersomnia, narcolepsy, central sleep apnea, obstructive sleep apnea, nocturnal seizures, periodic limb movement disorder (PLMD) and insomnia. Depending on etiology, management strategies include, but are not limited to, extension of time in bed, naps, surgery, various medical devices (e.g., oral appliance, continuous positive airway pressure) and medication therapy. (Colorado, 2005) Specifically, one study shows that both zopiclone and lorazepam are effective in the treatment of insomnia. Also, preliminary evidence demonstrates the value of Melatonin and Amitriptyline in treating sleep disorder post-TBI. (Kemp, 2004) (Li Pi Shan, 2004) (Ouellet, 2004) Bright light therapy, using blue light, may improve sleep and aid recovery after mild traumatic brain injury (TBI). In a small study of patients with mild TBI, researchers saw improvements in sleep, cognition, emotion, and brain function after 6 weeks of morning bright light therapy. Sleep disturbance is one of the most frequently reported subjective symptoms after mild TBI. Compared with placebo light, blue light therapy significantly reduced daytime sleepiness. More than half of the individuals in the treatment group showed a reduction in daytime sleepiness below the clinical cut-off on this self-report measure, compared to 0% in the placebo group. (Weber, 2013) See also Insomnia treatment in the Mental Chapter." UPTODATE SUMMARY AND RECOMMENDATIONS: 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 medical documentation provided indicates this patient was diagnosed with severe OSA, and that the patient had good results during the sleep study with CPAP. The treating physician has provided ongoing symptoms from this condition, a trial of home CPAP seems warranted. As such, the request for CPAP Set Up 1 Month Trial Rental with Supplies RFA Not Dated is medically necessary.