

<b>Case Number:</b>	CM14-0125945		
<b>Date Assigned:</b>	08/13/2014	<b>Date of Injury:</b>	09/07/2013
<b>Decision Date:</b>	10/24/2014	<b>UR Denial Date:</b>	07/11/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/08/2014

### 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 Physical Medicine & Rehabilitation and is licensed to practice in California and Washington. 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 injured worker is a 35-year-old male with a reported date of injury of 09/07/2013. The mechanism of injury was not noted in the records. The injured worker's diagnoses include head contusion, cervical discopathy, thoracic myofascitis, and lumbar myofascitis. The injured worker's past treatments included pain medication and physical therapy. There were no relevant diagnostic imaging studies provided. There was no relevant surgical history noted in the records. The subjective complaints on 05/19/2014 included difficulty speaking, slurred speech, and dizziness. The physical examination to the cervical spine noted that there is tenderness in the cervical spine at C4-7 and associated paraspinal muscles. There is a positive Spurling's test bilaterally. Assessment of the thoracic spine noted that there is tenderness in the upper thoracic spine at the T4, T5, T6, and T7 and associated paraspinal muscles. The lumbar spine evaluation noted that there is tenderness of the lumbar spine at L3-5 and associated paraspinal muscles. There is a positive Kemp's test bilaterally. There were no medications noted in the records. The treatment plan was to order a sleep study, order an Interspec IF 2 with supplies, and order speech therapy treatment. A request was received for sleep disordered breathing respiratory study 95806, overnight oximetry 94762, nasal function studies 92512, Interspec IF 2 and supplies, and speech therapy treatment frequency and duration unspecified. The rationale for the request was not provided. The Request for Authorization form was not provided in the records.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Sleep disordered breathing respiratory study 95806:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines: 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), Pain, Polysomnography

**Decision rationale:** The Official Disability Guidelines state polysomnography is recommended after at least 6 months of insomnia complaints (at least 4 nights/week), unresponsive to behavioral intervention and sleep/sedative promotive medications, and after psychiatric etiology has been excluded. Not recommended for routine evaluation of transient insomnia, chronic insomnia, or insomnia associated with psychiatric disorders. There is a lack of information in the clinical documentation that the patient has been unresponsive to behavioral intervention such as sleep or sedative promoting medications or the duration of the insomnia. Additionally there was no evidence that psychiatric etiology had been ruled out. Given the above, the request is not supported by the evidence-based guidelines. As such, the request is not medically necessary.

**Overnight Oximetry 94762:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines: 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), Pain, Polysomnography

**Decision rationale:** As the request for sleep disordered breathing respiratory study was not supported by the guidelines, the request for overnight oximetry is not supported by the guidelines as well. As such, the request is not medically necessary.

**Nasal Function Studies 92512:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines: Pulmonary, function testing

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain, Polysomnography

**Decision rationale:** As the request for sleep disordered breathing respiratory study is not supported by the guidelines, the request for nasal function study is not supported by the guidelines as well. As such, the request is not medically necessary.

