

<b>Case Number:</b>	CM14-0131703		
<b>Date Assigned:</b>	08/20/2014	<b>Date of Injury:</b>	05/06/2013
<b>Decision Date:</b>	10/23/2014	<b>UR Denial Date:</b>	07/30/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/18/2014

### 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 Occupational Medicine and is licensed to practice in California. 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 claimant was injured on 05/06/13. Sleep studies are under review. He has been treated by a chiropractor. On 07/16/14, he complained of constant moderate low back pain, stiffness, and cramping radiating to the buttocks. He had frequent severe right knee pain, numbness, and weakness radiating to the whole right leg and foot with numbness. He complained of loss of sleep due to pain with depression, anxiety, and irritability. He had tenderness of his low back and his knees and orthopedic measures caused pain. Diagnoses included low back sprain, rule out disc protrusion, radiculitis versus radiculopathy, right knee injury status post surgery, psych component, and internal diagnosis [sic]. On 03/14/14, he was considering ACL surgery but wanted a third opinion. He remained symptomatic. He was on Ultracet. He was on activity restrictions. His sleep complaints are not fully described.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Sleep Studies:** 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 (UPDATED 07/10/2014)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 chapter - polysomnography

**Decision rationale:** The history and documentation do not objectively support the request for sleep studies for this claimant who reports trouble sleeping due to pain with anxiety, depression, and irritability. The ODG state "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 the routine evaluation of transient insomnia, chronic insomnia, or insomnia associated with psychiatric disorders. Home portable monitor testing may be an option. A polysomnogram measures bodily functions during sleep, including brain waves, heart rate, nasal and oral breathing, sleep position, and levels of oxygen saturation. It is administered by a sleep specialist, a physician who is Board eligible or certified by the American Board of Sleep Medicine, or a pulmonologist or neurologist whose practice comprises at least 25% of sleep medicine. (Schneider-Helmert, 2003) According to page 3-17 of the AMA Guides (5th ed.), sleep disorder claims must be supported by formal studies in a sleep laboratory. (Andersson, 2000) However, home portable monitor testing is increasingly being used to diagnose patients with obstructive sleep apnea (OSA) and to initiate them on continuous positive airway pressure (CPAP) treatment, and the latest evidence indicates that functional outcome and treatment adherence in patients evaluated according to a home testing algorithm is not clinically inferior to that in patients receiving standard in-laboratory polysomnography. (Kuna, 2011) Insomnia is primarily diagnosed clinically with a detailed medical, psychiatric, and sleep history. Polysomnography is indicated when a sleep-related breathing disorder or periodic limb movement disorder is suspected, initial diagnosis is uncertain, treatment fails, or precipitous arousals occur with violent or injurious behavior. However, polysomnography is not indicated for the routine evaluation of transient insomnia, chronic insomnia, or insomnia associated with psychiatric disorders. (Littner, 2003) 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) Sleep-related breathing disorder or periodic limb movement disorder is suspected; & (7) 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, there are significant psychological issues and it is not clear that they have been resolved. In addition, the claimant has multiple reasons for sleep disturbance, including pain, depression, anxiety, and irritability. There is no evidence that he is likely to have sleep apnea and none of the ODG criteria have been described in the records. There is no evidence of daytime sleepiness or that the claimant falls asleep unexpectedly, or that he has intellectual deterioration or problems with his daily activities. The medical necessity of this request for sleep studies has not been demonstrated and is therefore, not medically necessary.