

<b>Case Number:</b>	CM15-0173760		
<b>Date Assigned:</b>	09/15/2015	<b>Date of Injury:</b>	07/31/2007
<b>Decision Date:</b>	10/21/2015	<b>UR Denial Date:</b>	08/07/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/03/2015

### 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: Maryland, Texas, Virginia

Certification(s)/Specialty: Internal Medicine, Allergy and Immunology, Rheumatology

### 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 45 year old male, who sustained an industrial injury on July 31, 2007. The injured worker was diagnosed as having sleep disturbance (deferred), cervical spine radiculopathy with myofascitis, and lumbar spine radiculopathy with myofascitis. Medical records (April 20, 2015 to July 23, 2015) indicate ongoing aching pain and stiffness of the neck, ongoing constant back pain with spasms and aching, and ongoing stress, anxiety, and depression. The physical exam (April 20, 2015 to July 23, 2015) reveals ongoing tenderness from the cervical spine down to the lumbar spine and limited range of motion of the cervical spine and lumbar spine. There was tenderness of the traps and positive axial compression. Per the treating physician (July 23, 2015 report), the injured worker is to continue with modified work including no lifting more than 5 pounds, no repetitive or awkward motions (bending, twisting, squatting, kneeling), no working above shoulder level, and 5 minute breaks every 1 hour worked to stretch, ice, heat, or rest affected injuries. Diagnostic studies were not included in the provided medical records. Surgeries to date have included left shoulder surgery in 2008. Treatment has included an ergonomic evaluation of his workstation, a trial of a sleep number bed, work restrictions, and pain medication (Norco). On July 27, 2015, the requested treatments included CPAP (continuous positive airway pressure) for home use. On August 7, 2015, the original utilization review non-certified a request for purchase of a CPAP (continuous positive airway pressure) unit for home uses.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Purchase of CPAP (continuous positive airway pressure) unit for home use: 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) Pulmonary Procedure Summary online version last update 5/27/2015.

**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:** The MTUS and ODG fail to address OSA and CPAP usage. Other criteria was utilized. Obstructive sleep apnea (OSA) is a disorder with serious co-morbidities. 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'.) UP-TO-DATE 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 records fail to demonstrate obstructive sleep apnea or a previous sleep study. As such, the request for CPAP is not medically necessary.