

<b>Case Number:</b>	CM15-0179971		
<b>Date Assigned:</b>	09/21/2015	<b>Date of Injury:</b>	08/02/2005
<b>Decision Date:</b>	10/26/2015	<b>UR Denial Date:</b>	08/12/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/14/2015

### 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: Connecticut, California, Virginia

Certification(s)/Specialty: Preventive Medicine, Occupational 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 52 year old female, who sustained an industrial-work injury on 8-2-05. A review of the medical records indicates that the injured worker is undergoing treatment for obstructive sleep apnea possible worsened because of weight gain, insomnia and disturbance in sleep patterns. Medical records dated (3-18-14 to 5-5-15) indicate that the injured worker has a history of sleep apnea that is not well controlled. The physician notes in the medical record dated 3-18-14 that the injured worker is not able to tolerate her continuous positive airway pressure (CPAP) and has had poor sleep and extreme fatigue on a regular basis. The medical record dated 5-5-15 the physician indicates that the injured worker states that "she does not sleep all night." She apparently goes to bed around 5AM and gets up around 3PM in the afternoon. She does not know why this is going on. The physician indicates that he had a lengthy discussion about her sleep hygiene and notes that she still snores. The injured worker is noted to be obese and uses a walker for ambulation. The injured worker reports that she uses her continuous positive airway pressure (CPAP) but that it is not doing very much and she does not feel rested and feels extremely tired. The physician indicates that "she has gained a good 20 pounds." The medical records also indicate worsening of the activities of daily living. The physical exam dated 5-5-15 reveals that the repeat neuro exam is essentially unchanged with a mallapatti of 3-4. Treatment to date has included pain medication, sleep studies in the past, psycho care, continuous positive airway pressure (CPAP) and other modalities. The request for authorization date was 5-5-15 and requested service included Sleep study QTY 1.00. The original Utilization review dated 8-12-15 non-certified the request as the injured worker was previously diagnosed with sleep apnea but

has poor sleep hygiene, uses medications that may interfere with her sleep and has gained weight, rationale for repeating polysomnogram without correcting these conditions, is not evident.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**Sleep study QTY 1.00:** 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 Chronic. Polysomnography.

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

**Decision rationale:** The ODG describes sleep studies as 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. Such studies are not recommended for the routine evaluation of transient insomnia, chronic insomnia, or insomnia associated with psychiatric disorders. In this case, the patient has a clear history warranting continued work up and treatment, and therefore a sleep study is unlikely to change management or clinical outcomes at this time. The patient has already been diagnosed with sleep apnea and there is little evidence to support that substantial improvements in other areas of sleep concern have been addressed successfully. Therefore, based on the guidelines, the request is not medically necessary at this time.