

Case Number:	CM15-0070055		
Date Assigned:	04/17/2015	Date of Injury:	08/15/2013
Decision Date:	06/05/2015	UR Denial Date:	04/02/2015
Priority:	Standard	Application Received:	04/14/2015

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: California

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 61 year old female, who sustained an industrial injury on August 15, 2015. She reported left wrist/thumb pain, right elbow pain, right wrist, neck and left shoulder pain. The injured worker was diagnosed as having status post left radial wrist surgery, right lateral epicondylitis, right wrist flexor tendinitis, cervical trapezial musculoligamentous sprain/strain, left shoulder tendinitis and impingement with associated periscapular myofascial strain and sleep difficulties secondary to chronic pain. Treatment to date has included radiographic imaging, diagnostic studies, surgical intervention, conservative care, physical therapy, occupational therapy, wrist brace, medications and work restrictions. Currently, the injured worker complains of left wrist/thumb pain, right elbow pain, right wrist, neck and left shoulder pain with associated insomnia. The insomnia was noted to be secondary to pain waking the patient frequently and was associated with daytime sleepiness and difficulty concentrating. The provider requested a sleep evaluation via a sleep specialist.

IMR ISSUES, DECISIONS AND RATIONALES

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

Sleep Study with Rapid Eye Movement (REM): 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), Pain (updated 03/23/15).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Schutte-Rodin S, et al. Clinical Guideline for the Evaluation and Management of Chronic Insomnia in Adults. J Clin Sleep Med 2008; 4 (5): 487-504.

Decision rationale: Insomnia is defined by the American Academy of Sleep Medicine (AASM) as the subjective perception of difficulty with sleep initiation, duration, consolidation, or quality that occurs despite adequate opportunity for sleep, and that results in some form of daytime impairment. It is the most prevalent sleep disorder in the general population. It requires a full work-up to understand its etiology and to direct therapy. The AASM guideline recommends any pharmacologic treatment for chronic insomnia be accompanied by cognitive and behavioral treatments. Additionally, it recommends use of benzodiazepines or benzodiazepine receptor agonist medications be used short term followed by other sedating agents such as sedating antidepressants and atypical antipsychotics. This patient has been complaining of frequent nighttime awakenings for over 7 months. The provider has requested testing to understand if the sleep problem and her associated with daytime symptoms are due to her industrial injury. A full evaluation for the etiology for her chronic insomnia has not been done but is appropriate as per the above guideline. The medical necessity for this evaluation has been established. Therefore, the requested treatment is medically necessary.