

Controversies in AMA Guides 5th Edition Rating Application of Sleep Disorders in Chapter 13

A sleep disorder rating as a "*compensable consequence*" problem is getting a lot of play these days. The concept is being pushed hard by CAAA and resisted with equal firmness by the Defense bar. They are indeed interesting and challenging for the AME receiving two such referral letters!

It may well take some Judicial decisions before all of this is sorted out. Until then, a community wide dialog would no doubt help, so feel free to chime in with your thoughts and views which will be published in the next Edition. To get the process started I'll offer some initial thoughts and pro-con style approaches to the issue.

In the face of this dispute I have attempted to study the issue long and hard. If Chapter 13 of the *AMA Guides 5th Edition* is read carefully, it will be evident that the "intended" use of Sleep Disorder ratings is for "Central Nervous System" (CNS) conditions. Plainly it does not appear to require any great thought to see the seeming disconnect in a schema that allows a sleep rating for conditions such as Parkinson's Disease or Multiple Sclerosis (CNS Disorders) producing reduced daytime alertness but then denies the rating for someone with a painful peripheral neuralgia (Peripheral Nervous System Disorder). If the emphasis is on decreased functioning because of genuinely impaired sleep, then the root source of the sleep problem would on the surface seem immaterial.

Still, on page 317 the *Guides* gives a very clear definition of the problem:

*"arousal and sleep disorders include **disorders related to initiating and maintaining sleep or inability to sleep**; excessive somnolence, including sleep-induced respiratory impairment; and sleep-wake cycles."*

Then the *Guides* inform us of disorders wherein a sleep disorder would be contemplated by stating:

*"Neurologic disorders associated with increased daytime sleepiness include central sleep apnea syndrome, narcolepsy, idiopathic hypersomnia, periodic limb movement disorder, restless leg syndrome, **depression**, brain tumors, posttraumatic hypersomnolence, multiple sclerosis, encephalitis and postencephalopathy, Alzheimer's disease, Parkinson's disease, multiple system atrophy, and neuromuscular disorders with sleep apnea."*

As can be seen, the list explicitly and unequivocally lists **Depression** as one of the accepted conditions. To my analysis, a diagnosis of **Depression** would therefore qualify for acceptable

"entry" into Table 13-4. This then would seem to open the door at least to injured workers who are depressed as a consequence of a physical injury.

This approach would appear to readily set the stage for a back and forth between both sides. The Applicant attorney could argue that the sleep disorder is non-psychiatric in appearance and effect, so that it wouldn't have to meet the "predominant causation" threshold required for finding derivative physical-mental injury AOE/COE. In contrast, the defense might well argue that secondary conditions from which all else flows is the depression which must pass predominant cause muster. As posited in the example, the sleep disorder is a derivative not of the physical injury directly, but rather itself derivative of the derivative! - A so-called grandchild compensable consequence that would result in it also being reliant on the acceptance of the predominant cause threshold for the psychiatric injury. This brings up yet further complication; treatment for the sleep disorder would be looked at differently, with the question reduced to whether or not care for that disorder could aid in recovery from the physical injury or the psychiatric.

It could also be argued - and has been by some - that a diagnosis of "*chronic pain syndrome*" would also meet the criteria as that is a condition which is indeed generally recognized as a (CNS) Disorder. (That is why spinal cord stimulators are used for example to treat chronic pain, because they deal with the CNS component of the pain.)

The Guides go on to tell us "*It is expected that the diagnosis of excessive daytime sleepiness has been supported by formal studies in a sleep laboratory*". This sentence is one of those classics that allows for differing interpretations. Some of the carriers such as SCIF are taking the position that a sleep study is necessary. Others point out that there is a difference between something that is "*expected*" (which The Guides states) and something that is "*required*" (which the Guides doesn't state).

My own view is that such studies are largely a waste of time, money and effort (If I thought otherwise I would immediately open a neurologic sleep clinic and start raking it in!). Do any of us really think that an injured worker is going to go through this nighttime experience in a laboratory with wires attached to his head and body, and get a normal night's sleep? Ridiculous! Moreover, the *Guides* actually go on to talk about the "clinical" use of the Epworth Scale which does not include a formal sleep study. Also, one of the examples cited under Section 13.3c does not include such a sleep study.

One final note on avoiding duplicative ratings. If the impact of insomnia on reduced daytime alertness has been taken into account by the Psychiatry AME when assessing the GAF, then it should not be used as a separate factor of impairment rating by the neuromusculoskeletal expert as then the same loss of function would be counted twice. I suspect that the concern over duplicate ratings is what controls the seeming arbitrary inclusions and exclusions in listed conditions for imposition of a WPI connected to sleep disorder. It appears that yet more arguments will be had as one side asks for rating by analogy and the other resists.