

Case Number:	CM13-0010889		
Date Assigned:	03/17/2014	Date of Injury:	11/29/2011
Decision Date:	04/30/2014	UR Denial Date:	08/08/2013
Priority:	Standard	Application Received:	08/14/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a Physician Reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The Physician Reviewer is Board Certified in Physical Medicine & Rehabilitation, has a subspecialty in Pain 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 Physician 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 patient is a 66 year old female who was injured on 11/29/2011. She was pushed down by a heavy bag and she hit her right shoulder on a pole. Diagnostic studies reviewed include MRI scan of the right shoulder performed on 12/06/2012 which revealed supraspinatus tendinopathy without full thickness tear, calcific tendinosis of the distal supraspinatus and infraspinatus, downsloping acromion process and thickening of the anterior inferior glenohumeral ligament suggestive of adhesive capsulitis. A Comprehensive Orthopedic Consultation dated 09/23/2013 documented the patient is status post industrial right shoulder sprain/strain lifting type injury, 11/29/2011 with continuous trauma from 09/24/2011 through 09/24/2012, with MRI scan-confirmed subacromial impingement, calcific tendinosis and adhesive capsulitis. The patient is an excellent candidate for right shoulder arthroscopic evaluation, arthroscopic subacromial decompression, distal clavicle resection, possible arthroscopic capsular release and manipulation under anesthesia. The patient will likely require three months of recovery following surgery before reaching a point of maximum medical benefit from orthopedic treatment. Initial Orthopedic consultation and Evaluation dated 03/12/2012 documented the patient to have diagnoses of cervical radiculopathy and cervical stenosis. Primary Treating Psychologist's Initial Report 11/12/2012 reported the patient to have undergone a Beck Depression inventory test, Beck Anxiety inventory test and Beck scale for suicidal ideation. First Report of Occupational Injury Report dated 01/29/2012 documented the patient to have a diagnosis of cervical strain. The Primary Treating Physician's Progress Report dated 02/01/2012 documented the patient to have diagnoses of cervical strain and shoulder/upper arm strain. PR2 dated 07/12/2013 indicated the patient complains of worsening right shoulder with pain and weakness and decreased motion since her last visit. She had 3 ESI (epidural steroid injections)

treatments without any improvement. She would like to proceed with surgery to her right shoulder. Objective findings on examination of the cervical spine revealed tenderness of the paraspinal with guarding and decreased range of motion. The right shoulder is tender (written notes are illegible). It is documented that the patient is not interested in a shoulder injection. She did not respond well to cortisone in the past.

IMR ISSUES, DECISIONS AND RATIONALES

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

FOUR BIOFEEDBACK SESSIONS: 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), Section Biofeedback Therapy Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 24.

Decision rationale: According to the MTUS guidelines, Biofeedback is not recommended as a stand-alone treatment, but recommended as an option in a cognitive behavioral therapy (CBT) program to facilitate exercise therapy and return to activity. The medical records do not demonstrate this employee is participating in a cognitive behavioral therapy program. The guidelines indicate there is fairly good evidence that biofeedback helps in back muscle strengthening, but evidence is insufficient to demonstrate the effectiveness of biofeedback for treatment of chronic pain. In absence of demonstrated participation in a CBT program, biofeedback is not recommended under the guidelines. Consequently, the request is non-certified.

PROSOM 2MG #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 24;. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Section Pain, Insomnia treatment: Estazolam.

Decision rationale: The MTUS guidelines indicate benzodiazepines are not recommended for long-term use because long-term efficacy is unproven and there is a risk of dependence. Most guidelines limit use to 4 weeks. Their range of action includes sedative/hypnotic, anxiolytic, anticonvulsant, and muscle relaxant. According to the ODG guidelines, FDA-approved benzodiazepines for sleep maintenance insomnia include Prosom (estazolam). These medications are only recommended for short-term use due to risk of tolerance, dependence, and adverse events (daytime drowsiness, anterograde amnesia, next-day sedation, impaired cognition, impaired psychomotor function, and rebound insomnia). Review of the medical records does not reveal subjective report of sleep difficulties. The medical records submitted do

not document any subjective complaints or corroborative clinical objective findings or observations as to establish an active diagnosis of insomnia. According to the referenced guidelines, benzodiazepines are not recommended for long-term use, and according to the ODG guidelines, Prosom is not recommended. Given that the diagnosis of insomnia is not evident, and Prosom is not recommended under the guidelines, the request is non-certified.