

Case Number:	CM15-0096628		
Date Assigned:	05/27/2015	Date of Injury:	11/28/2012
Decision Date:	06/25/2015	UR Denial Date:	04/29/2015
Priority:	Standard	Application Received:	05/20/2015

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: Physical Medicine & Rehabilitation

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 22-year-old female patient who sustained an industrial injury on 11/28/2012. A visit dated 04/09/2015 reported the patient with subjective complaint of having a depressed mood, anxiety, impaired sleep, diminished concentration, irritability, diminished appetite, weight loss, diminished libido, fatigue, worries, social detachment, and arguments with family, decreased motivation, suicidal thoughts, muscle tension and agitation. The following diagnoses are applied: major depressive disorder, moderate; generalized anxiety disorder, anxiety, depression, and insomnia secondary to pain. The treatment rendered noted medication consultation, biofeedback sessions, and sleep study performed. She is to return to modified work duty. On 02/02/2015 she underwent a magnetic resonance imaging study of the left shoulder which revealed the following: supraspinatus and infraspinatus tendinosis; minimal subcromial and subscapularis bursitis; minimal glenohumeral joint effusion; osteoarthropathy of acromioclavicular joint; lateral down slopping of acromion process noted with reduced acromioclavicular recess; biceps tenosynovitis; globular intrasubstance increase signal noted in superior labrum suggestive of degeneration versus partial tear. The left wrist revealed the following: ganglion cyst at the dorsal aspect of capitate; subchondral cyst/erosion at lunate; small radiocarpal and ulnocarpal joint effusion; partial tear of triangular fibrocartilage complex; mild osteoarthropathy of 1st carpometacarpal joint. The right shoulder showed partial tear of supraspinatus and infraspinatus tendons; minimal subcromial and subscapularis bursitis; minimal glenohumeral joint effusion; osteoarthropathy of acromioclavicular joint; lateral down slopping of acromion process with reduced acromioclavicular recess; biceps tenosynovitis, and globular

intrasubstance increase signal noted in superior labrum. The right wrist showed ganglion cyst at the volar aspect of radiocarpal joint; small radiocarpal, ulnocarpal, distal radioulnar and pisiotriquetral joint effusion; partial tear of triangular fibrocartilage complex and osteoarthropathy of 1st carpometacarpal joint. A recent primary treating office visit dated 01/24/2015 reported subjective complaint of having constant moderate dull, achy, sharp neck pain and stiffness; constant severe, dull, sharp, low back pain and stiffness; constant moderate sharp bilateral shoulder pain and stiffness, and bilateral constant severe sharp, stabbing, bilateral wrist pain. Objective findings showed tenderness to palpation of the lumbar paravertebral muscles along with spasm. There is tenderness to palpation of the anterior shoulder, posterior shoulder and supraspinatus. There is also tenderness to palpation of the lateral shoulder and Neer's cause's pain. She is also with tenderness to palpation of the medial wrist and a positive Tinel's maneuver. The following diagnoses are applied: cervical dysfunction' cervical strain/sprain; cervicgia; lumbar disc protrusion; lumbar myalgia; lumbar sprain/strain; right shoulder internal derangement; right shoulder strain/sprain; left shoulder muscle spasms; left shoulder pain; left shoulder strain/sprain; right carpal tunnel syndrome; left wrist neuralgia and left wrist pain. The plan of care noted the patient to continue with medications compound topical ointments, refer to orthopedic surgeon, urine analysis, acupuncture course, undergo a magnetic resonance imaging study and follow up visit.

IMR ISSUES, DECISIONS AND RATIONALES

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

Biofeedback; 8 sessions: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chapter 15, Stress Related Complaints, pages 387-405.

Decision rationale: It is unclear how many biofeedback sessions have been completed or if treatment is concurrent with Cognitive Behavioral Therapy (CBT). Per Guidelines, Biofeedback is not suggested as a stand-alone therapy, but may be incorporated after an adequate trial of CBT, not demonstrated here. The CBT must first show functional improvements and the necessity of the biofeedback as appropriate in order to deal better with the pain, improve functionality, and decrease medications; however, this has not been adequately demonstrated in the submitted reports as the patient's function remains unchanged with overall daily activities without decrease in pharmacological dosages, medical utilization, without progress or change in functional status post treatment already rendered. Medical necessity for Biofeedback has not been established and guidelines criteria are not met. The Biofeedback; 8 sessions is not medically necessary and appropriate.

Sleep study: 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).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Pain Chapter, Polysomnography, pages 822-823.

Decision rationale: ODG recommends Polysomnography 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. Criteria for the Polysomnography include (1) Excessive daytime somnolence; (2) Cataplexy (muscular weakness usually brought on by excitement or emotion, virtually unique to narcolepsy); (3) Morning headache (other causes have been ruled out); (4) Intellectual deterioration (sudden, without suspicion of organic dementia); (5) Personality change (not secondary to medication, cerebral mass or known psychiatric problems); & (6) Insomnia complaint for at least six months (at least four nights of the week), unresponsive to behavior intervention and sedative/sleep-promoting medications and psychiatric etiology has been excluded. Submitted reports have not adequately demonstrated support to meet the guidelines criteria in that the patient has clear psychological etiology having received psychotherapy. There are also no documented issues of specific insomnia with failure in pharmacological or psychotherapy treatment. The Sleep study is not medically necessary and appropriate.