MAXIMUS Federal Services

Case Number:	CM13-0025794		
Date Assigned:	02/07/2014	Date of Injury:	07/24/2001
Decision Date:	11/26/2014	UR Denial Date:	09/03/2013
Priority:	Standard	Application Received:	09/18/2013

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. The expert reviewer is Board Certified in Physical Medicine and 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 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/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 injured worker is a 57-year-old male with an original date of injury on July 24, 2001. The mechanism of injury was losing balance while stepping over some construction debris and twisting his back. The patient's industrially related diagnoses include chronic back pain, and degeneration of lumbar intra-vertebral disc. The patient had multiple bilateral L4, L5 and S-1 transforaminal epidural steroid injections with only temporary improvement. A CT scan of the lumbar spine dated September 2, 2011 documented depression along the superior end plate of the left aspect of the L1 vertebral body compatible with an age indeterminate compression fracture; multiple level degenerative spondylosis of lumbar spine; consider MRI of lumbar sacral spine for additional evaluation of disc disease. The patient's medication treatment plan include Tylenol #3, Paxil, and TENS unit. The disputed issues are referral to pain program and six visits of biofeedback. A utilization review determination on September 3, 2013 had noncertified these requests. The stated rationale for the denial was according to California MTUS guideline, "multidisciplinary care is beneficial for most persons with chronic pain, and likely should be considered the treatment of choice for persons who are at risk for, or who have, chronic pain and disability." Furthermore, the guideline states biofeedback as an option in a cognitive behavior therapy program to facilitate exercise therapy and return to activity. In the case of this injured worker, due to lack of documentation of failure of conservative care or of chronic pain and disability requiring multidisciplinary care, or requiring facilitation of exercise therapy and return to activity. The utilization review determined the requests for pain program and six visits of biofeedback not medically necessary.

IMR ISSUES, DECISIONS AND RATIONALES

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

6 visits of biofeedback: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Biofeedback Page(s): 24-25.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 24-25.

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines (Effective July 18, 2009) on pages 24-25 of 127 specify the following regarding biofeedback "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. 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. Biofeedback may be approved if it facilitates entry into a CBT treatment program, where there is strong evidence of success. As with yoga, since outcomes from biofeedback are very dependent on the highly motivated self-disciplined patient, we recommend approval only when requested by such a patient, but not adoption for use by any patient. EMG biofeedback may be used as part of a behavioral treatment program, with the assumption that the ability to reduce muscle tension will be improved through feedback of data regarding degree of muscle tension to the subject. The potential benefits of biofeedback include pain reduction because the patient may gain a feeling that he is in control and pain is a manageable symptom. Biofeedback techniques are likely to use surface EMG feedback so the patient learns to control the degree of muscle contraction. The available evidence does not clearly show whether biofeedback's effects exceed nonspecific placebo effects. It is also unclear whether biofeedback adds to the effectiveness of relaxation training alone. The application of biofeedback to patients with CRPS is not well researched. However, based on CRPS symptomology, temperature or skin conductance feedback modalities may be of particular interest. (Keefe, 1981) (Nouwen, 1983) (Bush, 1985) (Croce, 1986) (Stuckey, 1986) (Asfour, 1990) (Altmaier, 1992) (Flor, 1993) (Newton-John, 1995) (Spence, 1995) (Vlaeyen, 1995) (NIH-JAMA, 1996) (van Tulder, 1997) (Buckelew, 1998) (Hasenbring, 1999) (Dursun, 2001) (van Santen, 2002) (Astin, 2002) (State, 2002) (BlueCross BlueShield, 2004) This recent report on 11 chronic whiplash patients found that, after 4 weeks of myofeedback training, there was a trend for decreased disability in 36% of the patients. The authors recommended a randomized-controlled trial to further explore the effects of myofeedback training. (Voerman, 2006). See also Cognitive behavioral therapy (Psychological treatment)."In the case of this injured worker, there has been documentation of depression. However, there is no documentation of a cognitive behavior therapy program taking place at the present time. Biofeedback per the Chronic Pain Medical Treatment Guidelines is only recommended in the context of a cognitive behavioral program. Although the requesting physician wanted the biofeedback to certified concomitantly with the FRP, in which case CBT would be likely available, the FRP criteria have not been met and therefore biofeedback as standalone treatment is not appropriate. This request is not medically necessary.

Referral to pain program: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): 114.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Functional Restoration Programs.

Decision rationale: The Chronic Pain Medical Treatment Guidelines on pages 31-33 specify the following regarding functional restoration programs:Criteria for the general use of multidisciplinary pain management programs:Outpatient pain rehabilitation programs may be considered medically necessary when all of the following criteria are met:(1) An adequate and thorough evaluation has been made, including baseline functional testing so follow-up with the same test can note functional improvement; (2) Previous methods of treating chronic pain have been unsuccessful and there is an absence of other options likely to result in significant clinical improvement; (3) The patient has a significant loss of ability to function independently resulting from the chronic pain; (4) The patient is not a candidate where surgery or other treatments would clearly be warranted (if a goal of treatment is to prevent or avoid controversial or optional surgery, a trial of 10 visits may be implemented to assess whether surgery may be avoided); (5) The patient exhibits motivation to change, and is willing to forgo secondary gains, including disability payments to effect this change; & (6) Negative predictors of success above have been addressed.Integrative summary reports that include treatment goals, progress assessment and stage of treatment, must be made available upon request and at least on a bi-weekly basis during the course of the treatment program. Treatment is not suggested for longer than 2 weeks without evidence of demonstrated efficacy as documented by subjective and objective gains. (Note: Patients may get worse before they get better. For example, objective gains may be moving joints that are stiff from lack of use, resulting in increased subjective pain.) However, it is also not suggested that a continuous course of treatment be interrupted at two weeks solely to document these gains, if there are preliminary indications that these gains are being made on a concurrent basis. Total treatment duration should generally not exceed 20 full-day sessions (or the equivalent in part-day sessions if required by part-time work, transportation, childcare, or comorbidities). (Sanders, 2005) Treatment duration in excess of 20 sessions requires a clear rationale for the specified extension and reasonable goals to be achieved. Longer durations require individualized care plans and proven outcomes, and should be based on chronicity of disability and other known risk factors for loss of function."In the case of this injured worker, there has not been complete documentation of the 6 criteria as specified by the Chronic Pain Medical Treatment Guidelines for admission into a functional restoration program. Specifically, criteria number 1, an adequate and thorough evaluation of baseline functional testing is not clearly documented. With regards to criteria 2, previous methods of treating chronic pain such as epidural steroid injection of the lumbar spine were unsuccessful, however, no conservative treatment such as physical therapy were documented. Finally, criteria 6, negative predictors of success above have not been addressed. Without these documentations, this request is not medically necessary.