

Case Number:	CM13-0045545		
Date Assigned:	06/09/2014	Date of Injury:	08/07/2013
Decision Date:	07/28/2014	UR Denial Date:	10/24/2013
Priority:	Standard	Application Received:	11/12/2013

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 a licensed psychologist and is licensed to practice in Texas. 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 45-year-old female with a reported date of injury on 08/07/2013. The injury reportedly occurred when the injured worker bent down to assist in picking up an older man who had fallen on the floor and injured her neck/bilateral shoulders/low back/bilateral legs. Her previous treatments were noted to include acupuncture and medications. Her diagnoses were noted to include depressive disorder, general anxiety disorder, insomnia, psychological factors affecting pain, displacement of cervical intervertebral disc without myelopathy, cervical radiculopathy, degeneration of cervical intervertebral disc, myalgia, cervical spondylosis with myelopathy, and lumbar spondylosis. The progress report dated 03/05/2014 reported the injured worker felt sad, helpless, and hopeless. The injured worker reported feeling a loss of confidence in herself and a diminished sexual desire, as well as being lonely, afraid, irritable, and angry. The injured worker had difficulty remembering things and lost interest in her appearance. The examination performed noted the injured worker was tearful while describing work problems and her mood was sad and anxious. The injured worker's affect was appropriate to the content of her thoughts and thought processes were appropriate, logical, and coherent. The examination revealed the global assessment functioning score was rated at 55. The Request for Authorization form was not submitted within the medical records. The request for 12 cognitive behavioral psychotherapy sessions 1 times 12, 8 biofeedback modalities once a week for eight weeks, and 8 follow-up appointments; however, the provider's rationale was not submitted within the medical records. The request for 12 relaxation training once a week for twelve weeks for pain control.

IMR ISSUES, DECISIONS AND RATIONALES

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

TWELVE (12) COGNITIVE BEHAVIORAL GROUP PSYCHOTHERAPY 1 X 12:
Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 15 Stress Related Conditions Page(s): 400-401.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Behavioral Interventions.

Decision rationale: The California Chronic Pain Medical Treatment guidelines recommend cognitive behavioral therapy to identify and reinforce coping skills which are more useful in the treatment of pain than ongoing medication or therapy, which could lead to psychological or physical dependence. The guidelines criteria for cognitive behavioral therapy is to screen for patients with risk factors for delayed recovery, including fear avoidance beliefs. Initial therapy for these at risk patients should be physical medicine for exercise instruction, using a cognitive motivational approach to physical medicine. Consider separate psychotherapy CBT referral after 4 weeks if lack of progress from physical medicine alone. The guidelines recommend an initial trial of 3-4 psychotherapy visits over 2 weeks and with evidence of objective functional improvement, a total of up to 6-10 visits over 5-6 weeks (individual sessions). In this case, there is a lack of documentation regarding previous number of psychotherapy visits with evidence of objective functional improvement to warrant additional psychotherapy. Additionally, the guidelines recommend 3-4 initial visits and the request exceeds guideline recommendations. Therefore, the request for twelve cognitive behavioral group psychotherapy sessions once a week for twelve weeks is not medically necessary and appropriate.

EIGHT BIOFEEDBACK MODALITIES 1 X 8: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Biofeedback Page(s): 23-24.

Decision rationale: The California Chronic Pain Medical Treatment Guidelines do not recommend biofeedback as a standalone treatment, but recommend it as an option in a cognitive behavioral therapy program to facilitate exercise therapy and return to activity. There is rarely 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 cognitive behavioral therapy treatment program where there is strong evidence of success. The biofeedback therapy guidelines are to screen for patients with risk factors for delayed recovery, as well as motivation to comply with the treatment regimen that requires self discipline. Initial therapy for these at risk patients should be physical medicine exercise instruction using cognitive motivational approach to physical therapy. The guidelines may possibly consider biofeedback referral in conjunction with cognitive behavioral therapy; after 4 weeks after an initial trial of 3 to 4 psychotherapy visits over 2 weeks, with

evidence of objective functional improvement, a total up to 6 to 10 visits over 5 to 6 weeks, and patients may continue biofeedback exercises at home. In this case, the previous request for group cognitive behavioral therapy was non-certified which does not warrant biofeedback modalities. There is a lack of evidence regarding initial trial of 3 to 4 psychotherapy visits and there is a lack of objective functional improvement. Therefore, the request for eight biofeedback modalities once a week for eight weeks is not medically necessary and appropriate.

TWELVE (12) RELAXATION TRAINING 1 X 12: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 15 Stress Related Conditions Page(s): 400.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 15 Stress Related Conditions Page(s): 398-404.

Decision rationale: The MTUS/ACOEM guidelines state the majority of stress research has focused on stress management techniques for individuals. The guidelines state relaxation techniques may be particularly effective for individuals manifesting muscle tension. The psychology literature contains much information about meditation, relaxation techniques, and biofeedback for stress and anxiety with considerable debate on the theories and mechanism of action. To complicate matters, some techniques are offered alone or in conjunction with other modalities or are modifications of techniques. The goal of relaxation techniques is to teach the patient voluntarily change his psychological and cognitive functions in response to stressors. Relaxation techniques include meditation, relaxation response, and progressive relaxation. These techniques are advantageous because they can modify manifestations of daily, continuous stress. The main disadvantages are that formal training, at a cost, are usually necessary to master the technique and the techniques may not be suitable therapy for acute stress. In this case, there is a lack of documentation regarding previous biofeedback and cognitive behavioral therapy modalities which is a recognized form of self regulated relaxation method. The treatment options in terms of stress reduction for the injured worker is not yet known. Additionally, the previous request for cognitive behavioral therapy was non-certified. Therefore, the request for twelve relaxation training sessions, once a week for twelve weeks is not medically necessary and appropriate.

EIGHT (8) FOLLOW UP APPOINTMENTS: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 15 Stress Related Conditions Page(s): 405.

Decision rationale: The MTUS/ACOEM guidelines state the frequency of followup visits may be determined by the severity of symptoms, whether the injured worker was referred for further testing and/or psychotherapy, and whether the injured worker has missing work. These visits allow the physician and injured worker to reassess all aspects of the stress model (symptoms,

demands, coping mechanisms, and other resources and to reinforce the injured worker's supports and positive coping mechanisms. Generally, the injured worker's with stress related complaints can be followed by a midlevel practitioner every few days for counseling about coping mechanisms, medication use, activity modifications, and other concerns. These interactions may be conducted on site or by telephone to avoid interfering with modified or full duty work if the patient has returned to work. Followup by a physician can occur when a change in duty status is anticipated for at least once a week if the injured worker is missing work. In this case, there is a lack of documentation regarding the number previous psychological visits to warrant 8 follow-up visits as well as documentation regarding the results of those visits. Therefore, the request for eight follow up appointments is not medically necessary and appropriate.