

<b>Case Number:</b>	CM14-0018766		
<b>Date Assigned:</b>	04/18/2014	<b>Date of Injury:</b>	10/26/2010
<b>Decision Date:</b>	07/02/2014	<b>UR Denial Date:</b>	01/13/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/13/2014

### 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 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:

This 44 year-old female sustained an injury on 10/26/10 while employed by the [REDACTED]. Requests under consideration include BIOFEEDBACK ONE TIME A WEEK FOR SIX WEEKS and PHYSICAL THERAPY ONE TIME A WEEK FOR SIX WEEKS TO THE BILATERAL UPPER EXTREMITIES. Diagnoses include lateral epicondylitis, bursitis, insomnia, anxiety, and major depression current episode. Accepted part of claim includes the fingers. Most recently, the provider has added treatment request for psychologist, CBT and biofeedback for new onset of depression and anxiety as industrially related from this 2010 repetitive cumulative injury. Report of 10/1/13 from the provider noted the patient with complaints of symptoms of depression and anxiety, psychological distress, interfering sleep function, autonomic arousal, with preoccupation with her weight, difficulty coping, and feelings of fear and sadness. Psychological report noted psychological and environmental problems which are work-related and consistent with activity level reduction and relational problems. The patient has emotional withdrawal and relationship conflict relating to sexual issues as a result of chronic pain and cumulative trauma with decreased motivation and preoccupation with her body habitus. She recently lost 30 pounds which has elevated her mood. Report of 1/6/14 from the provider noted pain level of 4-5/10 having completed her last biofeedback sessions which has been beneficial to decrease her bilateral elbow and wrists sensitivity. PT has also been beneficial and she will have her last session in 2 days. The patient is s/p left elbow injection which has also been beneficial. She continues to utilize her medications which list Relafen, Buprenorphine sublingual, Prozac, and Tylenol. A peer-to-peer review was made on 1/13/14 and office provider noted he did not feel that he had a rationale for further biofeedback. The above requests for additional Biofeedback and PT were non-certified on 1/13/14 citing guidelines criteria and lack of medical necessity.

## IMR ISSUES, DECISIONS AND RATIONALES

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

### **BIOFEEDBACK ONE TIME A WEEK FOR SIX WEEKS: 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) Pain Chapter, Biofeedback Therapy.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 15 Stress Related Conditions Page(s): 400-401. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter, Biofeedback.

**Decision rationale:** This 44 year-old female sustained an injury on 10/26/10 while employed by the [REDACTED]. Requests under consideration include BIOFEEDBACK ONE TIME A WEEK FOR SIX WEEKS and PHYSICAL THERAPY ONE TIME A WEEK FOR SIX WEEKS TO THE BILATERAL UPPER EXTREMITIES. Diagnoses include lateral epicondylitis and bursitis with recently added insomnia, anxiety, major depression for this 2010 cumulative trauma injury involving the fingers. Per Guidelines, Biofeedback is not suggested as a stand-alone therapy, but may be incorporated after an adequate trial of Cognitive Behavioral Therapy (CBT). 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 opioid dosages, medical utilization, and has failed to progress with any work status post CBT already rendered. Medical necessity for Biofeedback has not been established and guidelines criteria are not met. The BIOFEEDBACK ONE TIME A WEEK FOR SIX WEEKS is not medically necessary and appropriate.

### **PHYSICAL THERAPY ONE TIME A WEEK FOR SIX WEEKS TO THE BILATERAL UPPER EXTREMITIES: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines PHYSICAL MEDICINE Page(s): 98-99.

**Decision rationale:** This 44 year-old female sustained an injury on 10/26/10 while employed by the [REDACTED]. Requests under consideration include BIOFEEDBACK ONE TIME A WEEK FOR SIX WEEKS and PHYSICAL THERAPY ONE TIME A WEEK FOR SIX WEEKS TO THE BILATERAL UPPER EXTREMITIES. Diagnoses include lateral epicondylitis and bursitis with recently added insomnia, anxiety, major depression for this 2010 cumulative trauma injury involving the fingers. Physical therapy is considered medically necessary when the services require the judgment, knowledge, and skills of a qualified physical

therapist due to the complexity and sophistication of the therapy and the physical condition of the patient. There is no clear measurable evidence of progress with previous PT including milestones of increased ROM, strength, and functional capacity. Provider's dated report has no documentation of new acute injury or flare-up to support for formal PT as the patient should continue his previously instructed independent home exercise program. Clinical exam indicates unchanged pain symptoms without neurological deficits or change in medical condition. The patient has received significant quantity of PT sessions of PT previously without functional improvement. Without documentation of current deficient baseline with clearly defined goals to be reached, medical indication and necessity for formal PT has not been established. The PHYSICAL THERAPY ONE TIME A WEEK FOR SIX WEEKS TO THE BILATERAL UPPER EXTREMITIES is not medically necessary and appropriate.