

<b>Case Number:</b>	CM14-0157064		
<b>Date Assigned:</b>	09/30/2014	<b>Date of Injury:</b>	12/24/2012
<b>Decision Date:</b>	11/17/2014	<b>UR Denial Date:</b>	09/17/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/25/2014

### 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 licensed in clinical psychology, 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:

According to the records provided for this IMR this patient is a 41 year-old female who reported an industrial related accident that occurred on December 24, 2012. The injury occurred during her work as a store manager or [REDACTED] where she worked for approximately seven years prior to the injury. The injury occurred when a shelving unit collapsed and fell onto the right side of her neck, upper back, and upper shoulder. She reports persistent right upper extremity and shoulder pain and continued depressive symptoms. Medically, she has been diagnosed with pain in joint, shoulder; neck pain. This IMR will focus on her psychological symptoms as they pertain to the current requested treatment. Psychologically, she has been diagnosed: Unspecified Major Depression, Recurrent Episode; Generalized Anxiety Disorder. There was a single diagnostic mention of PTSD but it was not found in any subsequent reports and was not confirmed in psychological testing. A treatment progress note from her primary physician August 2014 states that she has been authorized for 12 visits of psychological treatment and that there is also a pending request for evaluation and follow up with a psychiatrist to assess antidepressant medications. No progress notes from these 12 sessions were provided for this IMR. She has been prescribed the medication Lexapro for depression which she described as being somewhat helpful. A previous trial of the medication Effexor was discontinued due to side effects. Patient expressed a desire to discontinue Lexapro but it does not appear that that was done. She returned to work briefly in June 2013 but experienced severe pain and felt increasing anxiety with panic. A psychological consultation from June 2014 noted that the patient has significant anxiety and depression affecting her level of functioning. Symptoms were noted as: nervousness, uselessness and helplessness, difficulty focusing, reduced appetite, poor sleep because of pain and rumination about the future, panic attacks and flashbacks of injury. A progress note from March 2014 from her primary treating physician states that has been seeing a

psychologist for cognitive behavioral therapy and that her attorney is trying to find a provider closer to her home. She has participated in conventional medical treatments as well as physical therapy. A psychiatric reevaluation on April 2014 noted that she had been previously seen in November 2013, this noted that she saw a therapist only two times but it was not helpful as a therapist was young and in training and would often respond that she did not know how to help the patient. Psychiatrically, her mood is described as depressed often leading to the point of going to bed when in pain and feeling fatigued when awakened with no libido. She reports that when she sometimes goes to the grocery store she sees shelving similar to the ones that caused her injury and develops shortness of breath, sweating and panic and has to leave the store. A request was made for: follow-up for six sessions of biofeedback with psychiatrist. The request was made within the context of additional requests for cognitive behavioral therapy and group therapy. The request was made with a supportive statement: "I have assessed (her) to be highly motivated and self-disciplined. Expressed a strong interest in recovery from the apparent chronic pain condition and wants to reduce the reliance upon prescriptive medication. This pre-morbid history coupled with the patient's inherent personality predisposition point to a good therapeutic outcome utilizing a biofeedback modality. The request for "biofeedback treatment was not approved with the following UR rationale "psychological records indicate that the patient has been improving steadily. Although range of motion is still not appropriately normal after physical therapy, mood has improved, with the cognitive behavioral therapy and the prior biofeedback. Given the improvement, the patient may continue with biofeedback exercises at home. Further authorization is therefore not certified."

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**follow up for 6 sessions for biofeedback with psychiatrist:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 15 Stress Related Conditions. Decision based on Non-MTUS Citation Official Disability Guidelines Mental Illness and Stress (updated 06/12/2014)

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

**Decision rationale:** According to the MTUS treatment guidelines for biofeedback it is not recommended as a stand-alone treatment but is recommended as an option within a cognitive behavioral therapy program to facilitate exercise therapy and returned to activity. A biofeedback referral in conjunction with cognitive behavioral therapy after four weeks can be considered. An initial trial of 3 to 4 psychotherapy visits over two weeks is recommended at first and if there is evidence of objective functional improvement a total of up to 6 to 10 visits over a 5 to 6 week period of individual sessions may be offered, after completion of the initial trial of treatment and if medically necessary the additional sessions up to 10 maximum, the patient may "continue biofeedback exercises at home" independently. With respect to this patient, there were no treatment records provided whatsoever with regards to her past biofeedback sessions. There was mention, in the UR decision, that the patient has had prior biofeedback sessions but no further information was provided in treatment progress notes. There were no treatment progress notes provided from the clinical psychologist or psychiatrist discussing biofeedback. No biometric

measures before and after treatment were provided nor was there any indication of what treatment modalities in biofeedback were being used (for example GSR, EMG, or temperature training). There was no information about the patient's response to her biofeedback treatment. It is unclear if she was being taught to use the biofeedback exercises independently at home and if so was she successful in doing so. Individual session data was not provided with respect to biometric information. This is particularly important in biofeedback be able to assess what the sessions are consisting of and results that are being achieved. Is not 100% clear if she did in fact have prior biofeedback sessions because there was no documentation of them, if she has not had any biofeedback then it might be inappropriate request given that she is not a candidate for surgery. However the guidelines specify that 3 to 4 sessions should be given initially as a treatment trial with any subsequent sessions dependent on objective functional improvements. Due to lack of information supporting the request for additional sessions, in particular prior quantity/outcome of sessions provided, it is not possible to determine if 6 sessions would fall within the recommended guidelines of 6 to 10 maximum over a 5 to 6 week period. Therefore the request is not medically necessary.