

<b>Case Number:</b>	CM14-0067078		
<b>Date Assigned:</b>	07/11/2014	<b>Date of Injury:</b>	04/11/2008
<b>Decision Date:</b>	09/15/2014	<b>UR Denial Date:</b>	05/08/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/12/2014

### 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 Nevada. 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 records presented for review indicate that this 26 year old female was reportedly injured on 4/11/2008. The mechanism of injury is undisclosed. The most recent progress note, dated 2/21/2014. Indicates that there are ongoing complaints of low back pain that radiates in the bilateral lower extremities. The physical examination demonstrated thoracolumbar spine: positive tenderness to palpation spinous processes over the sacrum as well as paravertebral muscle spasms bilaterally, positive tenderness to palpation over coccyx and sacrum, limited range of motion lumbar spine with pain, straight leg raise test positive right sided 60 degrees, left sided 35 degrees, and Kemp's test positive bilaterally. No reason diagnostic studies are available for review. Previous treatment includes medications, and conservative treatment. A request was made for cognitive behavioral therapy, biofeedback, six sessions, and was not certified in the preauthorization process on 5/8/2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**cognitive behavioral therapy/biofeedback 6 sessions:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Programs Page(s): 30-34 of 127.

**Decision rationale:** Functional restoration programs (FRPs) are recommended where there is access to programs with proven successful outcomes (i.e., decreased pain and medication use, improved function and return to work, decreased utilization of the health care system), for patients with conditions that have resulted in delayed recovery. There should be evidence that a complete diagnostic assessment has been made, with a detailed treatment plan of how to address physiologic, psychological and sociologic components that are considered components of the patient's pain. Patients should show evidence of motivation to improve and return to work, and meet the patient selection criteria. After review of the medical documentation provided also unable to determine where patient had failed conservative treatment includes physical therapy. Also guidelines recommend three to four initial sessions to determine improvement in function as well as decrease in pain. The current request exceeds guideline recommendations with six sessions. Also please note there was no documentation of failed attempt to return to work. Therefore this request is deemed not medically necessary at this time.