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| <b>Case Number:</b>   | CM14-0128577 |                              |            |
| <b>Date Assigned:</b> | 09/05/2014   | <b>Date of Injury:</b>       | 01/24/2012 |
| <b>Decision Date:</b> | 02/27/2015   | <b>UR Denial Date:</b>       | 07/30/2014 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 08/13/2014 |

### 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: California

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine

### 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 made available for review, this is a 45-year-old male with a date of injury on 01/24/2012. Medical records from 02/26/2014 noted that the injured worker slipped on a pipe and fell on his knee subsequently injuring his left knee, left leg, and lower back. Documentation from 04/21/2014 indicated the diagnoses of lumbosacral spondylosis, pain in lower leg joint, sciatica, and sacral disorders. Subjective findings from 04/21/2014 was remarkable for constant left knee pain that worsens with walking and standing and a 25-30% slow improvement to low back pain with benefit from facet ablation procedure performed on 02/25/2014. Physical examination from the same date was remarkable for antalgic gait, tenderness to palpation at the lumbosacral junction with associated muscle tension and tenderness to palpation over the left knee medial joint with mild crepitus and grinding with passive range of motion. Range of motion to the lumbar spine was decreased by 30% with flexion, 20% with extension, and 20% with rotation bilaterally and the range of motion to the left knee was decreased by 20% with flexion, and full with extension. Documentation from 04/21/2014 noted magnetic resonance imaging from 11/21/2013 that was remarkable for irregularity along the tibial surface of the posterior horn of the medial meniscus, high grade patellofemoral chondrosis, partial thickness cartilage loss with fissuring, tendinosis of the popliteus tendon, prominent inferior patellar pole, and mild adjacent tendinosis of the patellar origin of the patellar tendon. Lumbar magnetic resonance imaging that was performed on 05/14/2013 was also noted that was revealing for a broad based disc bulge with facet joint arthropathy at lumbar four to five and broad based disc bulge deforming the thecal sac at lumbar

five to sacral one. Electromyogram to the bilateral lower extremities performed on 03/27/2013 was noted to be unremarkable. Prior treatments offered to the injured worker included facet ablation procedure performed on 02/25/2014, status post left knee surgery performed in 12/2012, diagnostic lumbar facet injection and epidural steroid injection, physical therapy, transcutaneous electrical nerve stimulation unit, and a medication history of Naproxen Sodium, Pantoprazole, Ketamine Cream, Buprenorphine, Gabapentin. While documentation indicated that physical therapy treatments were provided, there was no documentation of quantity, treatment plan, or results of prior physical therapy visits. The medical records provided also lacked documentation of effectiveness of medication regimen with regards to functional improvement, improvement in work function, or in activities of daily living. Physician documentation from 04/21/2014 noted restrictions of lifting 20 pounds; complete restriction from squatting, crawling, and kneeling; and alternating between sitting and standing as needed for pain. The physician noted the injured worker to be appropriate for modified duty, but if this is not provided then he is to remain as totally temporarily disabled. On 07/30/2014, Utilization Review non-certified the prescription for biofeedback office visits times four to six sessions. The biofeedback office visits was non-certified based on California DWC (2009) MTUS, Chronic Pain Medical Treatment Guidelines, page 24, noting that biofeedback is not recommended as a treatment by itself, but is recommended as treatment with cognitive behavioral therapy. Utilization Review also noted that medical records lacked documentation of physical therapy or a supervised exercise regimen along with no recommendation for cognitive behavioral therapy, thereby making the request for biofeedback office visits not medically necessary.

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

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

**Biofeedback Office Visits x 4-6 sessions:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Biofeedback section Page(s): 24, 25.

**Decision rationale:** The MTUS Guidelines do not recommend biofeedback as a stand-alone treatment, but recommend as an option in a cognitive behavioral therapy 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. It is recommended to screen for patients with risk factors for delayed recovery, as well as motivation to comply with a treatment regimen that requires self-discipline. Initial therapy for these at risk patients should be physical medicine exercise instruction, using a cognitive motivational approach to PT. Possibly consider biofeedback referral in conjunction with CBT after four weeks. The recommendations from the MTUS Guidelines are that biofeedback be considered after initiating cognitive behavioral therapy. The injured worker may benefit from biofeedback exercises, but this request

appears to be premature as cognitive behavioral therapy should be initiated prior to considering biofeedback. The requesting physician also has not addressed the suitability of this treatment method for this injured worker, so medical necessity has not been established.