

Case Number:	CM14-0187650		
Date Assigned:	11/17/2014	Date of Injury:	08/28/2013
Decision Date:	01/06/2015	UR Denial Date:	10/16/2014
Priority:	Standard	Application Received:	11/10/2014

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, has a subspecialty in Pain Medicine, Spinal Cord Medicine and is licensed to practice in Massachusetts. 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 claimant has a history of a work injury occurring on 08/28/13 while working as a truck driver with injury to her low back. Treatments included physical therapy, medications, and chiropractic care. She underwent lumbar medial branch radiofrequency ablation on 07/02/14. She then underwent physical therapy and as of 09/16/14 she had attended six treatments. She had increased range of motion and strength. She was independent in a home exercise program. She was seen on 09/16/14. There had been a 70% improvement after the radiofrequency ablation treatment. She was having lateral thigh pain. Pain was rated at 6/10. Medications were Flexeril and hydrocodone/acetaminophen. Physical examination findings included lumbar spine tenderness with increased paraspinal muscle tone. She had decreased and painful spinal range of motion. There was decreased lower extremity strength. She was continued at light duty. Authorization for epidural injections was requested. She was continued at temporary total disability.

IMR ISSUES, DECISIONS AND RATIONALES

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

6 Biofeedback Therapy (unspecified frequency & duration) for the Lumbar Spine as an Outpatient between 10/15/2014 and 11/29/2014: 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), www.odg-twc.com; Section: Low Back

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (Chronic), Biofeedback

Decision rationale: The claimant is more than one year status post work-related injury and continues to be treated for chronic low back pain. Treatments have included medications and recent medial branch radiofrequency ablation with improvement. Per ODG, biofeedback is not recommended as a stand-alone treatment, but is an option in a cognitive behavioral therapy program to facilitate exercise therapy and return to activity. In this case, the claimant is not participating in a cognitive behavioral therapy program and therefore, the requested biofeedback sessions are not medically necessary.