

<b>Case Number:</b>	CM15-0106170		
<b>Date Assigned:</b>	06/10/2015	<b>Date of Injury:</b>	03/12/2009
<b>Decision Date:</b>	07/10/2015	<b>UR Denial Date:</b>	05/22/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/01/2015

### 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: North Carolina  
 Certification(s)/Specialty: Family Practice

### 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 injured worker is a 53 year old female with an industrial injury dated 03/12/2009. Her diagnoses included chronic pain syndrome, post lumbar laminectomy syndrome, lower back pain, sciatica, lumbar/thoracic radiculopathy, sacroiliitis, spinal enthesopathy, and fasciitis, right foot drop and status post lumbar fusion. Prior treatment included medications, physical therapy and diagnostics. She presents on 05/06/2015 with complaints of lower back pain. She describes the pain as burning, radiating, sharp and stabbing. Pain is only better with rest and medications. She rates the pain as 9/10 with medications and 10/10 without medications. Physical exam revealed lumbar spinal tenderness and facet tenderness at lumbar 4- sacral 1 with positive lumbar facet loading maneuvers. There was tenderness with lateral compression of the sacroiliac joint on the left. There was significant foot drop of right foot. Treatment plan included left sacroiliac joint injection, medications, physical therapy and bio-behavioral pain management/biofeedback. The request is for bio-behavioral pain management/biofeedback.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Bio Behavioral Pain Management / biofeedback:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Psychological evaluation Page(s): 100.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, biofeedback.

**Decision rationale:** The California MTUS and the ACOEM do not specifically address the requested services. Per the Official Disability Guidelines section on biofeedback: 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 a physical medicine exercise instruction using a cognitive motivational approach to PT. Possibly consider biofeedback referral in conjunction with CBT after 4 weeks: Initial trial of 3-4 psychotherapy visits over 2 weeks. With evidence of objective functional improvement, total up to 6-10 visits over 5-6 weeks Patient may continue biofeedback exercises at home. In this case the request does not define the number of sessions. This is in excess of the ODG guidelines. Therefore the request is not certified. Therefore, the requested treatment is not medically necessary.