

<b>Case Number:</b>	CM15-0213583		
<b>Date Assigned:</b>	11/03/2015	<b>Date of Injury:</b>	05/07/2007
<b>Decision Date:</b>	12/21/2015	<b>UR Denial Date:</b>	10/05/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/29/2015

### 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: Massachusetts

Certification(s)/Specialty: Anesthesiology, Pain Management

### 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 65 year old male, who sustained an industrial injury on 05-07-2007. He has reported injury to the head, neck, right shoulder, and low back. The diagnoses have included spinal stenosis in cervical region; psychogenic headache; degeneration of lumbar intervertebral disc; lumbosacral radiculitis; major depressive disorder; cognitive disorder; and anxiety disorder. Treatment to date has included medications, diagnostics, bracing, walker, aquatic therapy, psychotherapy, and physical therapy. Medications have included Duexis, Hydromorphone, OxyContin, Cyclobenzaprine, Seroquel, Pristiq, and Pantoprazole. A progress report from the treating provider, dated 09-21-2015, documented an evaluation with the injured worker. The injured worker reported chronic low back pain; continuous unremitting headaches, secondary to tension and pain; depression and anxiety; pain rating during the previous week is noted as 7 out of 10 in intensity; aquatherapy has been helpful; and depression and anxiety have increased. It is noted by the provider that "although the patient has been enjoying significant improvement in pain since surgery, he still experiences a lot of pain and feels depressed, disappointed, and irritable; additionally, sleep has remained disrupted". Objective findings included functional improvements: increased awareness of cognitive distortions, increased awareness of pain avoidance behaviors, increased socialization, and improvement in non-pharmacological stress and pain management skills; also noted was reduction in symptoms of depression and reduction in pain avoidance beliefs. The treatment plan has included the request for 6 psychotherapy sessions; and 6 biofeedback sessions. The original utilization review, dated 10-05-2015, non-certified the request for 6 psychotherapy sessions; and 6 biofeedback sessions.

## IMR ISSUES, DECISIONS AND RATIONALES

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

### **6 psychotherapy sessions:** Overturned

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back, Psychological treatment.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Psychological treatment.

**Decision rationale:** According to the MTUS, Psychological treatment is recommended for appropriately identified injured workers during treatment for chronic pain. psychological intervention for chronic pain includes setting goals, determining appropriateness of treatment, conceptualizing a injured worker's pain beliefs and coping styles, assessing psychological and cognitive function, and addressing co-morbid mood disorders (such as depression, anxiety, panic disorder, and posttraumatic stress disorder). Cognitive behavioral therapy and self regulatory treatments have been found to be particularly effective. Psychological treatment incorporated into pain treatment has been found to have a positive short-term effect on pain interference and long-term effect on return to work. The following "stepped-care" approach to pain management that involves psychological intervention has been suggested: Step 1: Identify and address specific concerns about pain and enhance interventions that emphasize self-management. The role of the psychologist at this point includes education and training of pain care providers in how to screen for injured workers that may need early psychological intervention. Step 2: Identify injured workers who continue to experience pain and disability after the usual time of recovery. At this point a consultation with a psychologist allows for screening, assessment of goals, and further treatment options, including brief individual or group therapy. Step 3: Pain is sustained in spite of continued therapy (including the above psychological care). Intensive care may be required from mental health professions allowing for a multidisciplinary treatment approach. See also Multi-disciplinary pain programs. See also ODG Cognitive Behavioral Therapy (CBT) Guidelines. (Otis, 2006) (Townsend, 2006) (Kerns, 2005) (Flor, 1992) (Morley, 1999) (Ostelo, 2005) Further, the ODG also comment on CBT. The current evidence-based guidelines support the use of cognitive therapy for the treatment of stress related conditions. The official disability guidelines recommend cognitive therapy for depression. And initial trial of six visits over six weeks is recommended. A total of up to 13 to 20 visits over 13 to 20 weeks is recommended with evidence of objective functional improvement. According to the documents available for review, the IW meets criteria for an initial trial of 6 session of psychotherapy. Therefore, at this time, the requirements for treatment have been met and medical necessity has been established. The request is medically necessary.

### **6 biofeedback sessions:** 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), Low Back, Psychological treatment.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Biofeedback.

**Decision rationale:** Not recommended as a stand-alone treatment, but recommended as an option in a cognitive behavioral therapy (CBT) 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. As with yoga, since outcomes from biofeedback are very dependent on the highly motivated self-disciplined patient, we recommend approval only when requested by such a patient, but not adoption for use by any patient. EMG biofeedback may be used as part of a behavioral treatment program, with the assumption that the ability to reduce muscle tension will be improved through feedback of data regarding degree of muscle tension to the subject. The potential benefits of biofeedback include pain reduction because the patient may gain a feeling that he is in control and pain is a manageable symptom. Biofeedback techniques are likely to use surface EMG feedback so the patient learns to control the degree of muscle contraction. The available evidence does not clearly show whether biofeedback's effects exceed nonspecific placebo effects. It is also unclear whether biofeedback adds to the effectiveness of relaxation training alone. The application of biofeedback to patients with CRPS is not well researched. However, based on CRPS symptomology, temperature or skin conductance feedback modalities may be of particular interest. ODG biofeedback therapy guidelines: 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 4 weeks: Initial trial of 3-4 psychotherapy visits over 2 weeks - With evidence of objective functional improvement, total of up to 6-10 visits over 5-6 weeks (individual sessions) - Patients may continue biofeedback exercises at home. The MTUS recommends an initial trial of 3-4 biofeedback session over 2 weeks. The current request for 6 sessions is in contrast to the MTUS guidelines. Therefore, at this time, the requirements for treatment have not been met and medical necessity has not been established. The request is not medically necessary.