

<b>Case Number:</b>	CM15-0047446		
<b>Date Assigned:</b>	03/19/2015	<b>Date of Injury:</b>	07/21/2013
<b>Decision Date:</b>	04/24/2015	<b>UR Denial Date:</b>	03/09/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/12/2015

### 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: California  
Certification(s)/Specialty: Psychologist

### 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 female, who sustained an industrial injury on July 21, 2013. The injured worker had reported a head, neck and spine injury related to a fall. Current diagnoses include severe depression. Treatment to date has included medications and a psychological evaluation. Current documentation dated February 12, 2015 notes that the injured worker reported head, neck and spine pain rated at a seven out of ten on the Visual Analogue Scale. The injured worker also reported a depressed mood, reduced interest in activities, fatigue, worthlessness, diminished ability to think or concentrate, sleep disturbances and a decreased appetite in the past several weeks. The injured worker noted that the psychological symptoms were related to her injuries and the rate of improvement. A psychological evaluation noted the injured worker to have severe depression. The treating physician noted that the injured worker currently was experiencing psychological symptoms that had not yet been adequately treated. The treating physician's plan of care included a request for biofeedback therapy, four times a week for two weeks.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Biofeedback therapy 4 visits over 2 weeks:** Overturned

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Biofeedback. Decision based on Non-MTUS Citation Official Disability Guidelines, Biofeedback.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Part 2, Behavioral interventions, topic: Biofeedback Page(s): 24-25.

**Decision rationale:** According to the MTUS treatment guidelines for biofeedback it is not recommended as a stand-alone treatment but is recommended as an option within a cognitive behavioral therapy program to facilitate exercise therapy and returned to activity. A biofeedback referral in conjunction with cognitive behavioral therapy after four weeks can be considered. An initial trial of 3 to 4 psychotherapy visits over two weeks is recommended at first and if there is evidence of objective functional improvement a total of up to 6 to 10 visits over a 5 to 6 week period of individual sessions may be offered. After completion of the initial trial of treatment and if medically necessary the additional sessions up to 10 maximum, the patient may "continue biofeedback exercises at home" independently. A request was made for biofeedback sessions to be held over a two-week period. The request was non-certified by utilization review, the following rationale provided: "the request is premature until a psychological evaluation has been completed." According to the psychologist requesting the treatment (2/12/15) the patient has pain induced emotional and behavioral symptoms that include depression, anxiety, muscular bracing and irritability. The patient experienced depression and has significant neurologic that it Jatin of symptoms and poor coping skills and difficulty in pain management." The patient was diagnosed with major depressive disorder and sleep disorder and this request for biofeedback was in conjunction with cognitive behavioral therapy, psychoeducational group protocol, and office visit to include psychological testing and neural behavioral status exam. The utilization review determination for non-certification is inaccurate. It is not required that the patient have completed a psychological evaluation prior to the start of biofeedback treatment. In addition, a comprehensive 21 page psychological assessment was found in the medical chart from February 12, 2015 contains a significant and adequate documentation of the patient's psychological status and identifies her as a candidate for the requested treatment. The medical necessity of the request appears to be appropriate based on delayed recovery and significant psychological sequel and no history noted of prior psychological/biofeedback treatment is best as could be determined by the documentation provided. The medical necessity of the request is further substantiated by notations that the patient is experiencing muscle bracing in response to her pain condition, which can be addressed via biofeedback techniques. Because the requested treatment appears to be medically appropriate and necessary, the request to overturn the utilization review determination for non-certification is approved.