

Case Number:	CM15-0051862		
Date Assigned:	03/25/2015	Date of Injury:	10/10/2003
Decision Date:	05/01/2015	UR Denial Date:	02/24/2015
Priority:	Standard	Application Received:	03/19/2015

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: New Jersey, Michigan, California
 Certification(s)/Specialty: Neurology, Neuromuscular 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:

The injured worker is a 55 year old female, who sustained an industrial injury on 10/10/03. She has reported cervical, lumbar, shoulder and wrist injury. The diagnoses have included cervical disc displacement, lumbar disc displacement, and shoulder pain and carpal tunnel syndrome. Treatment to date has included diagnostics, durable medical equipment, and medications. There were no other noted treatments. Currently, as per the physician progress note dated 2/13/15, the injured worker was seen for follow up orthopedic exam. There were illegible notes but it was noted that she had a history of anxiety, depression and insomnia post industrial injury. She rated the pain 6/10 on pain scale. The physical exam revealed decreased range of motion and positive spasms in the cervical and lumbar spine. The right shoulder had positive impingement. The current medications were not noted. The physician requested treatments included Urinalysis for Toxicology, Psychological pain consultation, and Psych Bio Behavioral Pain Management 8-10 sessions.

IMR ISSUES, DECISIONS AND RATIONALES

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

Urinalysis for Toxicology: 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), Urine Toxicology.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, steps to avoid misuse/addiction Page(s): 77-78; 94.

Decision rationale: According to MTUS guidelines, urine toxicology screens is indicated to avoid misuse/addiction. (j) Consider the use of a urine drug screen to assess for the use or the presence of illegal drugs. There is no evidence that the patient have aberrant behavior for urine drug screen. There is no clear evidence of abuse, addiction and poor pain control. There is no documentation that the patient have a history of use of illicit drugs. Therefore, the request for Urine drug screen is not medically necessary.

Psychological pain consultation: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic pain programs, early intervention Page(s): 32-33.

Decision rationale: According to MTUS guidelines, the presence of red flags may indicate the need for specialty consultation. In addition, the requesting physician should provide a documentation supporting the medical necessity for a pain management evaluation with a specialist. The documentation should include the reasons, the specific goals and end point for using the expertise of a specialist. In the chronic pain programs, early intervention section of MTUS guidelines stated: Recommendations for identification of patients that may benefit from early intervention via a multidisciplinary approach: (a) The patient's response to treatment falls outside of the established norms for their specific diagnosis without a physical explanation to explain symptom severity. (b) The patient exhibits excessive pain behavior and/or complaints compared to that expected from the diagnosis. (c) There is a previous medical history of delayed recovery. (d) The patient is not a candidate where surgery or other treatments would clearly be warranted. (e) Inadequate employer support. (f) Loss of employment for greater than 4 weeks. The most discernible indication of at risk status is lost time from work of 4 to 6 weeks. (Mayer 2003). In this case, there is no clear documentation for the rational for the request for a psychology visit. There is no documentation of mental status evaluation or any documented findings consistent with depression or anxiety. The requesting physician did not provide a documentation supporting the medical necessity for consultation. The provider documentation should include the reasons, the specific goals and end point for using the expertise of a specialist. Therefore, the request for Psychological pain consultation is not medically necessary.

Psych Bio Behavioral Pain Management 8-10 sessions: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Biofeedback. <http://www.odg-twc.com/index.html>.

Decision rationale: According to ODG guidelines, biofeedback 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. (Keefe, 1981) (Nouwen, 1983) (Bush, 1985) (Croce, 1986) (Stuckey, 1986) (Asfour, 1990) (Altmaier, 1992) (Flor, 1993) (Newton-John, 1995) (Spence, 1995) (Vlaeyen, 1995) (NIH-JAMA, 1996) (van Tulder, 1997) (Buckelew, 1998) (Hasenbring, 1999) (Dursun, 2001) (vanSanten, 2002) (Astin, 2002) (State, 2002) (BlueCross BlueShield, 2004) This recent report on 11 chronic whiplash patients found that, after 4 weeks of myofeedback training, there was a trend for decreased disability in 36% of the patients. The authors recommended a randomized-controlled trial to further explore the effects of myofeedback training. (Voerman, 2006) See also Cognitive behavioral therapy (Psychological treatment) and Cognitive intervention (Behavioral treatment) in the Low Back Chapter. Functional MRI has been proposed as a method to control brain activation of pain. See Functional imaging of brain responses to pain. 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 therapy 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. There is no objective documentation that the patient is suffering from anxiety, stress and depression that will require biofeedback sessions. Therefore, the request for Psych Bio Behavioral Pain Management 8-10 sessions is not medically necessary.