

Case Number:	CM15-0064269		
Date Assigned:	04/10/2015	Date of Injury:	04/17/2010
Decision Date:	07/02/2015	UR Denial Date:	03/26/2015
Priority:	Standard	Application Received:	04/05/2015

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, Alabama, 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 59 year old female, who sustained an industrial injury on 04/17/2010. The injured worker was noted to be helping another person off the floor when the injured fall as well. She immediately experienced pain in lower back and neck, and abdomen that felt swollen. On provider visit dated 01/07/2015 the injured worker has reported cervical, thoracic, lumbar and bilateral upper extremity pain. Her pain was noted 7-8/10 without use of topical medication. On examination she was noted to have cervical, thoracic and lumbar paraspinal musculature, tender over the bilateral mid cervical facets. Upper and lower extremities were grossly motor intact. Lumbar extension reproduces thoracic pain. She was also noted to have mild depression. The diagnoses have included L5-S1 mild degenerative disc disease with moderate sized diffuse disc osteophyte, age indeterminate anterior wedge compression deformity of L1, C5-C6 and C6-C7 disc bulge with chronic strain and overlying myofascial pain, thoracic strain/sprain, reactive depression and thoracic degenerate disc disease. Treatment to date has included topical medication and TENS. The provider requested biofeedback therapy with pain psychologist 8 sessions and cognitive behavioral therapy with pain psychologist 8 sessions.

IMR ISSUES, DECISIONS AND RATIONALES

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

Biofeedback Therapy with Pain Psychologist, 8 sessions: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Biofeedback Page(s): 25. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Biofeedback Therapy Guidelines.

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) (van Santen, 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. In this case, the frequency of the treatment should be reduced from 8 to 4 or less sessions. More sessions will be considered when functional and objective improvements are documented. Therefore the request for Biofeedback Therapy with Pain Psychologist, 8 sessions is not medically necessary.

Cognitive Behavioral Therapy with Pain Psychologist, 8 sessions: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Behavioral Interventions Page(s): 23.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Cognitive Behavioral Therapy (CBT) guidelines for chronic pain.

Decision rationale: According to ODG guidelines, psychotherapy is recommended, Screen for patients with risk factors for delayed recovery, including fear avoidance beliefs. See Fear-avoidance beliefs questionnaire (FABQ). Initial therapy for these at risk patients should be physical medicine for exercise instruction, using a cognitive motivational approach to physical medicine. Consider separate psychotherapy CBT referral after 4 weeks if lack of progress from physical medicine alone: 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). Since the request for Biofeedback Therapy with Pain Psychologist, 8 sessions is not medically necessary, CBT 8 sessions is not medically necessary and appropriate.