

<b>Case Number:</b>	CM15-0082411		
<b>Date Assigned:</b>	05/04/2015	<b>Date of Injury:</b>	04/05/2009
<b>Decision Date:</b>	07/01/2015	<b>UR Denial Date:</b>	04/16/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/29/2015

### 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: California, Arizona, Maryland  
 Certification(s)/Specialty: Psychiatry

### 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 56 year old female, who sustained an industrial injury on 4/5/2009. Diagnoses have included lumbago, major depressive disorder, anxiety state, degeneration of lumbar/lumbosacral intervertebral disc, spinal stenosis of the lumbar region and thoracic/lumbosacral neuritis/radiculitis unspecified. Treatment to date has included cervical spine surgery, cognitive behavior pain psychology sessions and medication. According to the progress report dated 4/6/2015, the injured worker complained of lumbar pain. Physical exam revealed moderate to severe, generalized tenderness in the lumbar area. Gait was antalgic. The injured worker's mood and affect were depressed and anxious. Authorization was requested for H-Wave device for purchase; additional cognitive behavioral therapy (6 sessions); additional biofeedback (6 sessions); Lidoderm patches and Cymbalta.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**H-Wave Unit for purchase:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines H-Wave Stimulator Page(s): 117-118.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous Electrotherapy Page(s): 114-116.

**Decision rationale:** MTUS Chronic Pain Medical Treatment Guidelines do not recommend TENS as a primary treatment modality, but support consideration of a one-month home-based TENS trial used as an adjunct to a program of evidence-based functional restoration. Furthermore, criteria for the use of TENS includes pain of at least three months duration, evidence that other appropriate pain modalities have been tried (including medication) and failed, and a documented one-month trial period stating how often the unit was used, as well as outcomes in terms of pain relief and function. The request for H-Wave Unit for purchase is not medically necessary as the injured worker does not fulfill the above mentioned criteria for its use at this time.

**Additional Cognitive behavioral therapy (6 sessions):** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Psychological treatment Page(s): 23, 100-102.

**Decision rationale:** California MTUS states that behavioral interventions are recommended. The identification and reinforcement of coping skills is often more useful in the treatment of pain than ongoing medication or therapy, which could lead to psychological or physical dependence. ODG Cognitive Behavioral Therapy (CBT) guidelines for chronic pain recommends screening for patients with risk factors for delayed recovery, including fear avoidance beliefs. Initial therapy for these "at risk" patients should be physical medicine for exercise instruction, using 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). Upon review of the submitted documentation, it is gathered that the injured worker has had at least 14 psychotherapy sessions focused on CBT approach and there has been no mention of "objective functional improvement." The injured worker has already exceeded the upper limit of CBT sessions for chronic pain issues per the guidelines quoted above. Request for Additional Cognitive behavioral therapy (6 sessions) is not medically necessary at this time.

**Additional Biofeedback (6 sessions):** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topic: Biofeedback Page(s): 24.

**Decision rationale:** MTUS states "Biofeedback is 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." The injured worker has undergone prior CBT and biofeedback treatment. Per guidelines, biofeedback is 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. Since the injured worker has had prior treatment with both the above modalities before, the request for Additional Biofeedback (6 sessions) is excessive and not medically necessary.

**Lidoderm 5% patches #60 with 2 refills:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-112.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines: Topical analgesics Page(s): 111-112.

**Decision rationale:** The MTUS Chronic Pain Medical Treatment Guidelines p112 states Lidocaine Indication: Neuropathic pain Recommended for localized peripheral pain after there has been evidence of a trial of first-line therapy (tri-cyclic or SNRI antidepressants or an AED such as gabapentin or Lyrica). Topical lidocaine, in the formulation of a dermal patch (Lidoderm) has been designated for orphan status by the FDA for neuropathic pain. Lidoderm is also used off-label for diabetic neuropathy. No other commercially approved topical formulations of lidocaine (whether creams, lotions or gels) are indicated for neuropathic pain. The medical records submitted for review do not indicate that there has been a trial of first-line therapy (tri-cyclic or SNRI antidepressants or an AED). There is also no diagnosis of diabetic neuropathy or post-herpetic neuralgia. As such, lidoderm is not recommended at this time. The request is not medically necessary.