Case Number:	CM15-0087357		
Date Assigned:	05/11/2015	**Date of Injury:**	03/03/2014
Decision Date:	06/16/2015	**UR Denial Date:**	04/21/2015
Priority:	Standard	**Application Received:**	05/06/2015

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 year old female, who sustained an industrial injury on 03/03/2014. She has reported subsequent neck pain and was diagnosed with cervical disc degeneration of C5-C6, cervical disc herniation of C6-C7, anterior cervical discectomy and fusion and severe residual myofascial pain complaints. Treatment to date has included oral pain medication, cortisone injection of the shoulder and physical therapy. In a progress note dated 03/18/2015, objective findings were notable for decreased range of motion of the cervical spine. A request for authorization of 20 visits of biofeedback and relaxation therapy and psychological consultation and treatment of an unspecified duration was submitted.

IMR ISSUES, DECISIONS AND RATIONALES

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

Biofeedback and Relaxation Therapy, 20 visits: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Biofeedback.

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." There is no objective documentation that the patient is suffering from anxiety, stress and depression that will require biofeedback sessions. Therefore, the request for Biofeedback and Relaxation Therapy, 20 visits is not medically necessary.

Psychological consultation and treatment, unspecified duration: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): 398.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Psychological evaluations http://www.odg-twc.com/index.html.

Decision rationale: According to ODG guidelines, psychological evaluation is "Recommended based upon a clinical impression of psychological condition that impacts recovery, participation in rehabilitation, or prior to specified interventions (e.g., lumbar spine fusion, spinal cord stimulator, implantable drug-delivery systems). (Doleys, 2003) Psychological evaluations are generally accepted, well-established diagnostic procedures not only with selected use in pain problems, but also with more widespread use in subacute and chronic pain populations. Diagnostic evaluations should distinguish between conditions that are preexisting, aggravated by the current injury or work related. Psychosocial evaluations should determine if further psychosocial interventions are indicated. The interpretations of the evaluation should provide clinicians with a better understanding of the patient in their social environment, thus allowing for more effective rehabilitation. (Main-BMJ, 2002) (Colorado, 2002) (Gatchel, 1995) (Gatchel, 1999) (Gatchel, 2004) (Gatchel, 2005) For the evaluation and prediction of patients who have a high likelihood of developing chronic pain, a study of patients who were administered a standard battery psychological assessment test found that there is a psychosocial disability variable that is associated with those injured workers who are likely to develop chronic disability problems. (Gatchel, 1999) Childhood abuse and other past traumatic events were also found to be predictors of chronic pain patients. (Goldberg, 1999) Another trial found that it appears to be feasible to identify patients with high levels of risk of chronic pain and to subsequently lower the risk for work disability by administering a cognitive-behavioral intervention focusing on psychological aspects of the pain problem. (Linton, 2002) Other studies and reviews support these theories. (Perez, 2001) (Pulliam, 2001) (Severeijns, 2001) (Sommer, 1998) In a large RCT the benefits of improved depression care (antidepressant medications and/or psychotherapy) extended beyond reduced depressive symptoms and included decreased pain as well as improved functional status. (Lin-JAMA, 2003) See "Psychological Tests Commonly Used in the Assessment of Chronic Pain Patients" from the Colorado Division of Workers Compensation, which describes and evaluates the following 26 tests: (1) BHI 2nd ed - Battery for Health Improvement, (2) MBHI, Millon Behavioral Health Inventory [has been superseded by the MBMD following, which should be administered instead], (3) MBMD Millon Behavioral Medical Diagnostic, (4) PAB, Pain Assessment Battery, (5) MCMI-111, Millon Clinical Multiaxial Inventory, (6) MMPI-2, Minnesota Inventory, (7) PAI, Personality Assessment Inventory, (8) BBHI 2, Brief Battery for Health Improvement, (9) MPI, Multidimensional Pain Inventory, (10) P-3, Pain Patient Profile, (11) Pain Presentation Inventory, (12) PRIME-MD, Primary Care Evaluation for Mental Disorders, (13) PHQ, Patient Health Questionnaire, (14) SF 36, (15) SIP, Sickness Impact Profile, (16) BSI, Brief Symptom Inventory, (17) BSI 18, Brief Symptom Inventory, (18) SCL-90, Symptom Checklist, (19) BDI;II, Beck Depression Inventory, (20) CES-D, Center for Epidemiological Studies Depression Scale, (21) PDS, Post Traumatic Stress Diagnostic Scale, (22) Zung Depression Inventory, (23) MPQ, McGill Pain Questionnaire, (24) MPQ-SF, McGill Pain Questionnaire Short Form, (25) Oswestry Disability Questionnaire, (26) Visual Analogue Pain Scale VAS. (Bruns, 2001) Chronic pain may harm the brain, based on using functional magnetic resonance imaging (fMRI), whereby investigators found individuals with chronic back pain (CBP) had alterations in the functional connectivity of their cortical regions, areas of the brain that are unrelated to pain, compared with healthy controls. Conditions such as depression, anxiety, sleep disturbances, and decision-making difficulties, which affect the quality of life of chronic pain patients as much as the pain itself, may be directly related to altered brain function as a result of chronic pain. (Baliki, 2008) Maladjusted childhood behavior is associated with the likelihood of chronic widespread pain in adulthood. (Pang,

2010) Psychosocial factors may predict persistent pain after acute orthopedic trauma, according to a recent study. The early identification of those at risk of ongoing pain is of particular importance for injured workers and compensation systems. Significant independent predictors of pain outcomes were high levels of initial pain, external attributions of responsibility for the injury, and psychological distress. Pain-related work disability was also significantly predicted by poor recovery expectations, and pain severity was significantly predicted by being injured at work. (Clay, 2010) See also Comorbid psychiatric disorders. See also the Stress/Mental Chapter." There is no documentation that the patient developed psychological dysfunction impacting her ability to recover form her cervical surgery or her ability to perform rehabilitation. Therefore, the request for Psychological consultation and treatment, unspecified duration is not medically necessary.