

<b>Case Number:</b>	CM14-0147431		
<b>Date Assigned:</b>	09/15/2014	<b>Date of Injury:</b>	10/16/2012
<b>Decision Date:</b>	11/14/2014	<b>UR Denial Date:</b>	08/28/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/10/2014

### 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. The expert reviewer is Board Certified in Psychiatry and Neurology and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

According to the records made available for review, this is a 59-year-old female with a 10/16/12 date of injury. At the time (8/20/14) of request for authorization for PR-2 Report, Xanax 0.5mg qd #42, Hydrocodone 10/325mg qd #30, Orphenadrine 10mg qd #30, Lumbar Spine Rehab Kit, Psych follow-up x6, Biofeedback x1, and Psych Testing (x2 Units), there is documentation of subjective (ongoing neck pain, mid back pain, and low back pain with stiffness; headaches; and insomnia/stress/depression) and objective (tenderness to palpation over the cervical spine, thoracic spine and lumbar spine with spasms and sensory changes; right leg weakness; and decreased range of motion of the cervical and lumbar spine) findings, current diagnoses (brachial neuritis/radiculitis, cervical intervertebral disc disorder without myelopathy, thoracic sprain, pain disorder, depressive disorder, and anxiety disorder), and treatment to date (psychotherapy including biofeedback training and cognitive behavioral therapy (unknown amount) with positive response; completion of physical therapy; and medications (including Xanax since at least 6/4/14, and ongoing therapy with Hydrocodone, and Orphenadrine since at least 3/14/14)). Medical report identifies a request to continue with psychotherapy (including biofeedback training and cognitive behavioral therapy). Regarding PR-2 Report, there is no documentation that the request represents medical treatment. Regarding Xanax 0.5mg qd #42, there is no documentation of short-term (less than 4 weeks) treatment; functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of Xanax use to date. Regarding Hydrocodone 10/325mg qd #30, there is no documentation that the prescriptions are from a single practitioner and are taken as directed; the lowest possible dose is being prescribed; and there will be ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects; and functional benefit or improvement as a reduction in work restrictions; an increase in activity

tolerance; and/or a reduction in the use of medications as a result of Hydrocodone use to date. Regarding Orphenadrine 10mg qd #30, there is no documentation of acute exacerbation of chronic pain, short-term (less than two weeks) treatment, and functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of Orphenadrine use to date. Regarding Lumbar Spine Rehab Kit, there is no documentation that the patient has been taught appropriate home exercises by a therapist or medical provider; and a description of the exact contents of the kit. Regarding Psych follow-up x6, the number of previous psychotherapy treatments cannot be determined, and there is no documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services as a result of psychotherapy provided to date. Regarding Biofeedback x1, the number of previous biofeedback treatments cannot be determined, and there is no documentation of an intention for biofeedback therapy to facilitate exercise therapy and return to activity; and functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services as a result of biofeedback therapy provided to date.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**PR-2 Report:** 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 <http://www.cigna.com/healthcare-professionals/resources-for-health-care-professionals/clinical-payment-and-reimbursement-policies/medical-necessity-definitions>

**Decision rationale:** MTUS and ODG do not address this issue. Medical Treatment Guideline identifies documentation that the request represents medical treatment in order to be reviewed for medical necessity, as criteria necessary to support the medical necessity of the requested PR-2 Report. Within the medical information available for review, there is documentation of diagnoses of brachial neuritis/radiculitis, cervical intervertebral disc disorder without myelopathy, thoracic sprain, pain disorder, depressive disorder, and anxiety disorder. However, there is no documentation that the request represents medical treatment. Therefore, based on guidelines and a review of the evidence, the request for PR-2 Report is not medically necessary.

**Xanax 0.5mg qd #42:** Upheld

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

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

**Decision rationale:** MTUS Chronic Pain Medical Treatment Guidelines identifies that benzodiazepines are not recommended for long-term use and that most guidelines limit use to 4 weeks. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. Within the medical information available for review, there is documentation of diagnoses of brachial neuritis/radiculitis, cervical intervertebral disc disorder without myelopathy, thoracic sprain, pain disorder, depressive disorder, and anxiety disorder. However, given documentation of ongoing treatment with Xanax since at least 6/4/14, there is no documentation of short-term (less than 4 weeks) treatment. In addition, there is no documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of Xanax use to date. Therefore, based on guidelines and a review of the evidence, the request for Xanax 0.5mg qd #42 is not medically necessary.

**Hydrocodone 10/325mg qd #30:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-80.

**Decision rationale:** MTUS Chronic Pain Medical Treatment Guidelines necessitate documentation that the prescriptions are from a single practitioner and are taken as directed; the lowest possible dose is being prescribed; and there will be ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects, as criteria necessary to support the medical necessity of opioids. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. Within the medical information available for review, there is documentation of diagnoses of brachial neuritis/radiculitis, cervical intervertebral disc disorder without myelopathy, thoracic sprain, pain disorder, depressive disorder, and anxiety disorder. However, there is no documentation that the prescriptions are from a single practitioner and are taken as directed; the lowest possible dose is being prescribed; and there will be ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. In addition, given documentation of ongoing treatment with Hydrocodone since at least 3/14/14, there is no documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of Hydrocodone use to date. Therefore, based on guidelines and a review of the evidence, the request for Hydrocodone 10/325mg qd #30 is not medically necessary.

**Orphenadrine 10mg qd #30:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain) Page(s): 63-64. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Muscle relaxants (for pain)

**Decision rationale:** MTUS Chronic Pain Medical Treatment Guidelines identifies documentation of acute exacerbation of chronic low back pain and used as a second line option for short-term treatment, as criteria necessary to support the medical necessity of muscle relaxant. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. ODG identifies that muscle relaxants are recommended for short-term (less than two weeks) treatment. Within the medical information available for review, there is documentation of diagnoses of brachial neuritis/radiculitis, cervical intervertebral disc disorder without myelopathy, thoracic sprain, pain disorder, depressive disorder, and anxiety disorder. In addition, there is documentation of chronic pain and spasms. However, there is no documentation of acute exacerbation of chronic pain. In addition, given documentation of ongoing treatment with Orphenadrine since at least 3/14/14, there is no documentation of short-term (less than two weeks) treatment. Furthermore, there is no documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of Orphenadrine use to date. Therefore, based on guidelines and a review of the evidence, the request for Orphenadrine 10mg qd #30 is not medically necessary.

**Lumbar Spine Rehab Kit:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter, Exercise; Knee & Leg Chapter, Home Exercise Kit

**Decision rationale:** MTUS does not address the issue. ODG identifies that there is strong evidence that exercise programs, including aerobic conditioning and strengthening, are superior to treatment programs that do not include exercise; that there is no sufficient evidence to support the recommendation of any particular exercise regimen over any other exercise regimen; that a therapeutic exercise program should be initiated at the start of any treatment or rehabilitation program, unless exercise is contraindicated; and that such programs should emphasize education, independence, and the importance of an on-going exercise regimen. In addition, ODG identifies a home exercise kit is recommended as an option where home exercise programs are recommended; that the patient has been taught appropriate home exercises by a therapist or medical provider; and a description of the exact contents of the kit. Within the medical information available for review, there is documentation of diagnoses of brachial neuritis/radiculitis, cervical intervertebral disc disorder without myelopathy, thoracic sprain, pain disorder, depressive disorder, and anxiety disorder. However, despite documentation of completion of physical therapy, there is no (clear) documentation that the patient has been taught appropriate home exercises by a therapist or medical provider. In addition, there is no

documentation of a description of the exact contents of the kit. Therefore, based on guidelines and a review of the evidence, the request for Lumbar Spine Rehab Kit is not medically necessary.

**Psych follow-up x6: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Behavioral interventions Page(s): 23; 101-102.

**Decision rationale:** MTUS Chronic Pain Medical Treatment Guidelines identifies documentation of chronic pain or co-morbid mood disorders (such as depression, anxiety, panic disorder, and posttraumatic stress disorder), as criteria necessary to support the medical necessity of psychological treatment. MTUS Guidelines go on to recommend an initial trial of 3-4 psychotherapy visits over 2 weeks, and with evidence of objective functional improvement, a total of 6-10 visits over 5-6 weeks (individual sessions). MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. Within the medical information available for review, there is documentation of diagnoses of brachial neuritis/radiculitis, cervical intervertebral disc disorder without myelopathy, thoracic sprain, pain disorder, depressive disorder, and anxiety disorder. In addition, there is documentation of ongoing psychotherapy and a request for psych follow-up x6 (with the intention that the requested psych follow-up x6 is to provide additional psychotherapy). Furthermore, there is documentation of chronic pain and co-morbid mood disorders (depression and anxiety). However, there is no documentation of the number of previous psychotherapy visits to determine if psychotherapy guidelines have been exceeded or will be exceeded with the additional request. In addition, despite documentation of "positive response with previous psychotherapy", there is no (clear) documentation of objective functional improvement and functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services as a result of psychotherapy provided to date. Therefore, based on guidelines and a review of the evidence, the request for Psych follow-up x6 is not medically necessary.

**Biofeedback x1: 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) Psychotherapy Guidelines

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Biofeedback Page(s): 24-25. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Biofeedback

**Decision rationale:** MTUS Chronic Pain Medical Treatment Guidelines identifies 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. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. ODG identifies documentation of chronic pain and a lack of progress after 4 weeks of physical medicine using a cognitive motivational approach, as criteria necessary to support the medical necessity of biofeedback in conjunction with CBT. Furthermore, ODG supports an initial trial of 4 visits, and with evidence of objective functional improvement, a total of up to 6-10 visits. Within the medical information available for review, there is documentation of diagnoses of brachial neuritis/radiculitis, cervical intervertebral disc disorder without myelopathy, thoracic sprain, pain disorder, depressive disorder, and anxiety disorder. In addition, there is documentation of ongoing psychotherapy including biofeedback training and cognitive behavioral therapy, with a request for continued treatment. However, there is no documentation of the number of previous biofeedback sessions to determine if biofeedback guidelines have been exceeded or will be exceeded with the additional request. In addition, there is no documentation of an intention for biofeedback therapy to facilitate exercise therapy and return to activity. Furthermore, despite documentation of "positive response with previous biofeedback therapy", there is no (clear) documentation of objective functional improvement and functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services as a result of biofeedback therapy provided to date. Therefore, based on guidelines and a review of the evidence, the request for biofeedback x1 is not medically necessary.

**Psych Testing (x2 Units):** 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 Behavioral interventions Page(s): 23; 101-102.

**Decision rationale:** MTUS Chronic Pain Medical Treatment Guidelines identifies documentation of chronic pain or co-morbid mood disorders (such as depression, anxiety, panic disorder, and posttraumatic stress disorder), as criteria necessary to support the medical necessity of psychological treatment. ODG supports psychological testing (including BHI - Battery for Health Improvement, MBHI - Millon Behavioral Health Inventory, MBMD - Millon Behavioral Medical Diagnostic, PAB - Pain Assessment Battery, MCMI-111 - Millon Clinical Multiaxial Inventory, MMPI-2 - Minnesota Inventory, PAI - Personality Assessment Inventory, BBHI 2 - Brief Battery for Health Improvement, MPI - Multidimensional Pain Inventory, P-3 - Pain Patient Profile, Pain Presentation Inventory, PRIME-MD - Primary Care Evaluation for Mental Disorders, PHQ - Patient Health Questionnaire, SF 36, SIP - Sickness Impact Profile, BSI - Brief Symptom Inventory, BSI 18 - Brief Symptom Inventory, SCL-90 - Symptom Checklist, BDI-II - Beck Depression Inventory, CES-D - Center for Epidemiological Studies Depression Scale, PDS - Post Traumatic Stress Diagnostic Scale, Zung Depression Inventory, MPQ - McGill Pain

Questionnaire, MPQ-SF - McGill Pain Questionnaire Short Form, Oswestry Disability Questionnaire, Visual Analogue Pain Scale - VAS) in the evaluation/management of patients with chronic pain and/or reactive symptoms of stress/anxiety/depression. Within the medical information available for review, there is documentation of diagnoses of brachial neuritis/radiculitis, cervical intervertebral disc disorder without myelopathy, thoracic sprain, pain disorder, depressive disorder, and anxiety disorder. In addition, there is documentation of chronic pain and co-morbid mood disorders (depression and anxiety). However, the proposed number of psych testing sessions (x2 Units) exceeds guidelines. Therefore, based on guidelines and a review of the evidence, the request for Psych Testing (x2 Units) is not medically necessary.