

<b>Case Number:</b>	CM14-0151272		
<b>Date Assigned:</b>	09/19/2014	<b>Date of Injury:</b>	07/12/2012
<b>Decision Date:</b>	10/21/2014	<b>UR Denial Date:</b>	08/22/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/17/2014

### 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 psychology 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 that were provided for this IMR, this patient is a 54 year-old male who reported an industrial/occupational injury that occurred on July 12, 2012 during his work for Apple Termite. On that date he was working in his usual and customary work duties as a termite technician doing carpenter work replacing a rotted wood patio when he had a puncture wound to the right hand that became infected and developed severe cellulitis and abscess. The condition was made worse by uncontrolled diabetes, and he developed gangrene. He is status post amputation of the right ring finger and partial metacarpal bone (May 2013) and status post below the knee amputation (March 2014). This IMR will address symptoms related to his psyche only. The patient had a psychological evaluation conducted in June 2014. He has not returned to work and has trouble nearly all activities of daily living. He is described as sad, angry, frustrated, living in a constant state of anxiety and worry about his future and health. At the time of his initial evaluation therapy to help them with noninvasive pain management techniques hoping with his physical limitations post surgery. His Beck depression inventory score was 29 and the Beck anxiety inventory score was 22. Treatment plan was described as: "psychotherapy for stress reduction and assisting him to cope more adequately with physical pain, developing resources to cope with chronic pain, teaching relaxation training and cognitive behavioral therapy to assist to reduce depressive and anxious symptoms." A PR-2 treatment note (no date by the psychologist but stamped September 30, 2014) stated that he has been diagnosed with: Major Depression, Single Episode, Moderate Severity; Pain Disorder; Phantom Pain with Depression. The treatment plan is listed as continuing cognitive behavioral therapy and biofeedback training and mentions that the patient is worried about "weight gain and exercise and getting use to his new prosthesis and is trying to keep his thoughts positive." There was no mention of any evidence of objective functional improvements, nor was there any mention of the total number of sessions the patient

has had to date or his subjective response to treatment. It is not clear if the patient received biofeedback training during this session or not, no biofeedback metrics were provided. Beck Depression Inventory score was 25 and Beck Anxiety Inventory score was 22. Additional treatment progress notes were found.

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

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

**Biofeedback x 1:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Behavioral Interventions, Biofeedback Page(s): 24-25.

**Decision rationale:** Documentation that was provided for this IMR was insufficient to substantiate the medical necessity for additional biofeedback visits. Although nearly 1400 pages were provided only a few addressed the patient's psychological symptoms and treatment. A comprehensive psychological evaluation was provided that documented the patient's psychological diagnoses and one progress note from the patient's treating psychologist was found. It is unclear how many sessions the patient has had to date. Current request for additional treatment sessions is for 1 biofeedback session. According to the MTUS treatment guidelines, biofeedback is: "not recommended as a stand-alone treatment but is recommended as an option in a cognitive behavioral therapy program to facilitate exercise therapy and returned activity... Biofeedback may be approved if it facilitates entry into a cognitive behavioral treatment program where there is a strong evidence of success. As with yoga, single 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... Patients should be screened for delayed recovery as well as motivation to comply with the treatment regime that requires self-discipline. Initial therapy for these "at risk" patients should be physical medicine exercise instruction, including a cognitive motivational approach to PT." An initial trial of 3 to 4 visits over two weeks can be followed up with an additional total of up to 6-10 visits over a 5 to 6 period of individual sessions; if there is evidence of objective functional improvement. Afterwards patients may continue biofeedback exercises at home. Because the submitted progress note did not mention the patient's motivation, nor did it provide any biometric results such as EMG readings, or mention the biofeedback training in any manner, there was insufficient documentation of the patient's prior treatment sessions. The total quantity of prior sessions already received is unknown, and there was no evidence of objective functional improvement derived from prior biofeedback treatment. It is not even clear whether or not the patient has received prior biofeedback treatment or if he just received cognitive behavioral therapy. It is also not clear whether or not the patient is engaged in a cognitive behavioral treatment program for which the requested biofeedback treatment would be a part of for if this is for a stand-alone session, which is not recommended. Additional sessions are contingent on evidence of objective functional improvements, and not solely psychological symptomology. Objective functional improvement is defined as an increase in activities of daily living, a reduction in dependency on

future medical care, and a reduction in work restrictions if applicable. There was a repeated BDI and BAI (Beck depression and anxiety inventories) comparing from the initial psychological evaluatio