

Case Number:	CM15-0127679		
Date Assigned:	07/14/2015	Date of Injury:	03/26/2013
Decision Date:	08/11/2015	UR Denial Date:	06/29/2015
Priority:	Standard	Application Received:	07/01/2015

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 47 year old female, who sustained an industrial injury on March 26, 2013. The injured worker reported sustaining injuries to the neck, back, arms, and legs after she was struck by a motor vehicle while she was walking causing her to be thrown 10 feet. The injured worker was diagnosed as having an episode of mental and clinical disorder, insomnia, and post traumatic stress disorder. Treatment and diagnostic studies to date has included physical therapy, electromyogram with nerve conduction velocity, and cognitive behavioral therapy. In a progress note dated June 16, 2015 the treating psychologist reports sleep disturbances, depressed mood, reduced interest in activities, diminished ability to think or concentrate, excessive worry or anxiety, difficulty in controlling the worry, feeling restless, difficulty concentrating, flashbacks of the event, dreams about the event, and distress when exposed to cues that resemble the event. The treating psychologist also noted the injured worker to have difficulty with activities of daily living, social functioning, concentrating, and stress tolerance. The treating psychologist noted that two prior psychology group sessions assisted the injured worker with expressing herself and also assisted the injured worker to learn skills, but the documentation did not indicate if the injured worker experienced any functional improvement with previous sessions of cognitive behavioral therapy and biofeedback. The treating physician requested a follow up office visit with a psychologist to assess the injured worker's response to treatment. The treating physician also requested ten sessions of cognitive behavioral therapy and ten sessions of biofeedback due to the injured worker experiencing anxiety, with generalized autonomic hyper arousal.

IMR ISSUES, DECISIONS AND RATIONALES

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

Follow up office visit (QTY: 1): Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): 89.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Assessing Red Flags and Indication for Immediate Referral, Chronic pain programs, early intervention Page(s): 171, 32-33.

Decision rationale: According to MTUS guidelines, the presence of red flags may indicate the need for specialty consultation. In addition, the requesting physician should provide a documentation supporting the medical necessity for a surgery evaluation with a specialist. The documentation should include the reasons, the specific goals and end point for using the expertise of a specialist. In the chronic pain programs, early intervention section of MTUS guidelines stated: "Recommendations for identification of patients that may benefit from early intervention via a multidisciplinary approach: (a) The patient's response to treatment falls outside of the established norms for their specific diagnosis without a physical explanation to explain symptom severity. (b) The patient exhibits excessive pain behavior and/or complaints compared to that expected from the diagnosis. (c) There is a previous medical history of delayed recovery. (d) The patient is not a candidate where surgery or other treatments would clearly be warranted. (e) Inadequate employer support. (f) Loss of employment for greater than 4 weeks. The most discernible indication of at risk status is lost time from work of 4 to 6 weeks. (Mayer 2003)." The requesting physician did not provide a documentation supporting the medical necessity for a follow up evaluation. The documentation did not include the reasons, the specific goals and end point for using the expertise of a specialist for the patient pain. Therefore the request for Follow up visit is not medically necessary.

10 additional psychotherapy sessions: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation 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)." There is no documentation of functional improvement with the previous Psychological Therapy Sessions. Therefore, the request for additional Psychological Therapy 10 Sessions is not medically necessary.

10 sessions of biofeedback: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 24-25. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

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 is not medically necessary.