

<b>Case Number:</b>	CM15-0098721		
<b>Date Assigned:</b>	06/01/2015	<b>Date of Injury:</b>	10/06/2011
<b>Decision Date:</b>	07/07/2015	<b>UR Denial Date:</b>	04/30/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/21/2015

### 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

Certification(s)/Specialty: Physical Medicine & Rehabilitation

### 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 38-year-old male who sustained an industrial injury on October 6, 2011. He has reported injury to bilateral hands and has been diagnosed with status post cervical fusion and status post cervical myelopathy secondary to herniated disc. Treatment has included medications, physical therapy, surgery, medical imaging, and acupuncture. The injured worker had full range of motion of the cervical spine without Lhermitte's phenomenon with minimal tenderness. He had normal resistive strength in the upper and lower extremities with normal tone. He had slightly decreased strength and coordination in his hands. His reflexes were hypoactive except for his ankle reflexes which were 2+. The treatment request included cognitive behavioral therapy; follow up office visit, and biofeedback therapy.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Cognitive Behavioral Therapy 1x10:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Behavioral Intervention Page(s): 23-25. Decision based on Non-MTUS Citation Official disability guidelines Pain chapter, Cognitive Behavioral Therapy (CBT).

**Decision rationale:** The patient presents with neck, back, arms and legs pain rated 8/10. The request is for COGNITIVE BEHAVIORAL THERAPY 1 X 10. The request for authorization is dated 04/20/15. The patient is status-post C5-6 ACDF with graft and plating, 03/12/12. MRI of the cervical spine, 02/28/12, shows large 16 x 9-mm right central disc protrusion at C5-6 severely compressing the cord greater than 80%. Physical examination of the cervical spine reveals range of motion movements produce suboccipital axial discomfort. Spurling's maneuver is positive to the left side down his left arm into the forearm and hand. The sensory examination shows that this patient has non-anatomical diminished pinprick in the legs. In terms of depressive based symptoms, the patient reports experiencing feelings of sadness, a loss of pleasure in participating in usual activities, sleep disturbance, appetite changes, crying episodes and denied suicidal ideation. In terms of anxiety base symptoms, the patient reports experiencing feelings of insecurity, health worries, nightmares and fears related to his accident, panic attacks and symptoms of physical trembling, shortness of breath, excessive perspiration and chest pains. Patient's medications include Wellbutrin, Xanax and Gabapentin. Per progress report date 04/11/15, the patient is temporarily totally disabled. MTUS Chronic Pain Medical Treatment Guidelines page 23-25 has the following under Behavioral Intervention: "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. See also Multi-disciplinary pain programs.ODG Cognitive Behavioral Therapy (CBT) guidelines for chronic pain: 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)." Per progress report dated 04/11/15, treater's reason for the request is "for additional Cognitive Behavioral Therapy (CBT) sessions because the patient continues to struggle with chronic pain and co-morbid mood disorders." Per request for authorization dated 04/20/15, the treater is requesting "Quantity: 6-10 visits, Frequency: 1x weekly, Duration; over 5-6 weeks." In this case, it appears the patient has previously attended CBT sessions and the treater is requesting additional visits of CBT following an initial trial. MTUS recommends up to 6-10 visits over 5-6 weeks with evidence of objective functional improvement. However, review of provided medical records did not include any documentation or discussion by treater regarding the functional improvement of the patient. Therefore, the request IS NOT medically necessary.

**Follow-Up Office Visit 1x4:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 15 Stress Related Conditions Page(s): 405.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official disability guidelines Mental Illness & Stress Chapter, Office visits.

**Decision rationale:** The patient presents with neck, back, arms and legs pain rated 8/10. The request is for FOLLOW-UP OFFICE VISIT 1 X 4. The request for authorization is dated 04/20/15. The patient is status-post C5-6 ACDF with graft and plating, 03/12/12. MRI of the cervical spine, 02/28/12, shows large 16 x 9-mm right central disc protrusion at C5-6 severely compressing the cord greater than 80%. Physical examination of the cervical spine reveals range of motion movements produce suboccipital axial discomfort. Spurling's maneuver is positive to the left side down his left arm into the forearm and hand. The sensory examination shows that this patient has non-anatomical diminished pinprick in the legs. In terms of depressive based symptoms, the patient reports experiencing feelings of sadness, a loss of pleasure in participating in usual activities, sleep disturbance, appetite changes, crying episodes and denied suicidal ideation. In terms of anxiety base symptoms, the patient reports experiencing feelings of insecurity, health worries, nightmares and fears related to his accident, panic attacks and symptoms of physical trembling, shortness of breath, excessive perspiration and chest pains. Patient's medications include Wellbutrin, Xanax and Gabapentin. Per progress report date 04/11/15, the patient is temporarily totally disabled. ODG-TWC, Mental Illness & Stress Chapter, under Office visits, "Recommended as determined to be medically necessary. The need for a clinical office visit with a health care provider is individualized based upon a review of the patient concerns, signs and symptoms, clinical stability, and reasonable physician judgment." Per prescription for treatment report dated 04/11/15, treater's reason for the request is "to assess functional response to recommended treatment in order to issue Progress (PR2) Report." In this case, the recommended treatment of Cognitive Behavioral Therapy and Biofeedback Therapy has not been authorized. Therefore, the request IS NOT medically necessary.

**Biofeedback Therapy 1x10:** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official disability guidelines Low Back -Lumbar and Thoracic- Chapter, Biofeedback.

**Decision rationale:** The patient presents with neck, back, arms and legs pain rated 8/10. The request is for BIOFEEDBACK THERAPY 1 X 10. The request for authorization is dated 04/20/15. The patient is status-post C5-6 ACDF with graft and plating, 03/12/12. MRI of the cervical spine, 02/28/12, shows large 16 x 9-mm right central disc protrusion at C5-6 severely compressing the cord greater than 80%. Physical examination of the cervical spine reveals range of motion movements produce suboccipital axial discomfort. Spurling's maneuver is positive to the left side down his left arm into the forearm and hand. The sensory examination shows that this patient has non-anatomical diminished pinprick in the legs. In terms of depressive based symptoms, the patient reports experiencing feelings of sadness, a loss of pleasure in participating in usual activities, sleep disturbance, appetite changes, crying episodes and denied suicidal ideation. In terms of anxiety base symptoms, the patient reports experiencing feelings of insecurity, health worries, nightmares and fears related to his accident, panic attacks and symptoms of physical trembling, shortness of breath, excessive perspiration and chest pains. Patient's medications include Wellbutrin, Xanax and Gabapentin. Per progress report date 04/11/15, the patient is temporarily totally disabled. MTUS does not specifically address

biofeedback, though the ODG Low Back -Lumbar and Thoracic- Chapter, under Biofeedback states:"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 low back 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. There is conflicting evidence on the effectiveness of biofeedback for treating patients with chronic low back problems." Per progress report dated 04/11/15, treater's reason for the request is "I have assessed this patient to be highly motivated and self-disciplined. The patient has expressed a strong interest in recovery from the apparent chronic pain condition and wants to reduce the reliance upon prescriptive medication. Moreover, this patient has generally demonstrated good pre-morbid physical health and was an active exerciser." ODG supports biofeedback therapy as an adjunct in cases where Cognitive Behavioral Therapy is being utilized. However, the request for Cognitive Behavioral Therapy has not been authorized. Therefore, the request IS NOT medically necessary.