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Notice of Independent Review Decision

DATE OF REVIEW: August 13, 2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Four Biofeedback therapy sessions between June 25, 2010, and August 24, 2010

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION

Psychologist, Member American Academy of Pain Management

REVIEW OUTCOME

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

Upheld (Agree)

Medical documentation **does not support** the medical necessity of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Office visits (11/09/09 – 07/20/10)
- Physical Therapy (11/10/09 – 07/20/10)
- Diagnostics (12/03/09 – 02/04/10)
- Medical Reviews/DDE (03/23/10, 04/01/10)
- Right shoulder surgery (04/12/10)

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- Office visit (12/21/09 - 05/13/10)
- Right shoulder surgery (04/12/10)
- Utilization review (06/04/10 – 06/30/10)

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TDI

- Utilization review (06/04/10 – 06/30/10)

[ODG has been utilized for the denials.](#)

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who on xx/xx/xx, was working (three person job) transferring 50-lb load and felt pain to his right shoulder, right side of ribs and

lumbar spine but he continued to work. Pain progressed that night and next day. He reported to supervisor who told him to keep working. The patient worked for four hours and then saw doctor.

Initially, the patient was seen by, D.C., at Clinic, for pain in the right rib, right shoulder and lumbar spine. Examination of the thoracic spine revealed positive sternal compression and rib compression tests. Examination of the lumbar spine revealed positive tests including toe walk, Kemp's, Lasegue's, straight leg raise (SLR) on the right side as well as Yeoman's and Milgram's. Examination of the right shoulder revealed positive Apley's scratch, apprehension and supraspinatus tests. There was decreased cervical lordosis. Dr. diagnosed shoulder sprain/strain, thoracic spine sprain/strain with intercostal neuralgia and lumbar herniated disc/disc bulge/rupture. He treated the patient with 12 sessions of physical therapy (PT) consisting of hot/cold packs, interferential current, manual therapy for the cervical and lumbar spine and active modalities consisting of exercises.

X-rays of the lumbar spine revealed straightened lumbar curvature possibly due to spasm or positioning and disc space thinning and facet settling at L5-S1. X-rays of the thoracic spine revealed mild thinning of the disc at mid to upper thoracic levels and mild listing deformity at mid to upper thoracic levels. X-rays of the right shoulder were unremarkable.

In a behavioral medicine consultation, , M.A, M.Ed., LPC., noted a score of 32 on Beck Depression Inventory (BDI) indicating severe depression and 9 on Beck Anxiety Inventory (BAI) consistent with mild anxiety. She assessed adjustment disorder with mixed anxiety and depressed mood secondary to work injury and recommended six sessions of individual psychotherapy and evaluation for psychotropic medication along with concurrent use of antidepressant medication.

In January 2010, magnetic resonance imaging (MRI) of the right shoulder revealed type II superior labrum anterior posterior (SLAP) tear of the superior biceps labral anchor, tendinosis of the distal insertional supraspinatus tendon and narrowing of the coracoacromial arch secondary to lateral downsloping of the acromion, acromioclavicular (AC) spurring and type II acromion compressing the superior surface of the supraspinatus muscle tendon bundle.

MRI of the lumbar spine revealed left paracentral 6-7 mm disc herniation at L5-S1 displacing the descending left S1 nerve roots posteriorly and effacing the exiting left L5 nerve root at the entrance of the left neural foramen; a broad-based posterior 2-mm disc protrusion at L4-L5 and a posterocentral 2-mm disc protrusion at L3-L4 effacing, but not compressing the thecal sac.

M.D., an orthopedic surgeon, saw the patient for right shoulder pain. The ongoing medication was ibuprofen. Dr. obtained a diagnostic ultrasound that revealed minimal fluid and x-rays of the right shoulder which showed type II acromion at the AC joint. He assessed right shoulder SLAP tear, tendinosis of supraspinatus, shoulder sprain/strain and type II AC joint. He prescribed Medrol Dosepak, Celebrex, Darvocet and Flexeril; administered dexamethasone and lidocaine in the right subacromial region and referred the patient to Dr. for evaluation of herniated disc at L5-S1. The subacromial injection gave only a

temporary pain relief. Dr. recommended right shoulder surgery in view of failed conservative treatment.

On March 22, 2010, Ms. noted the patient had attended six sessions of individual psychotherapy. The BDI score decreased from 32 to 16 consistent with mild reduction and BAI score from 9 to 6 consistent with minimal anxiety. She assessed mild anxiety secondary to work injury and recommended four additional sessions of individual psychotherapy and biofeedback therapy.

On March 23, 2010, D.O., a designated doctor, deferred assessment of maximum medical improvement (MMI) and recommended shoulder surgery by Dr. and surgery for the herniated lumbar disc by Dr.. He stated the patient was unable to return to work.

M.D., saw the patient for low back pain radiating to the left leg. He noted decreased lumbar range of motion (ROM) and decreased motor strength and sensation to the left lower extremity. He reviewed the MRI of the lumbar spine and diagnosed lumbar HNP at L5-S1, left lower extremity sciatica and S1 radiculopathy and recommended lumbar epidural steroid injection (ESI) prior to left L5-S1 microdiscectomy.

On April 12, 2010, Dr. performed right shoulder arthroscopy, SLAP debridement and repair, synovectomy, rotator cuff repair, partial distal clavicular resection and acromioplasty with coracoacromial ligamentum incision.

Postoperatively, the patient attended extensive active PT. He was continued on medications.

On May 13, 2010, Ms. noted the patient had attended four sessions of biofeedback and four sessions of individual psychotherapy. Total of 10 sessions of both had been completed. There was increase in BAI from 24 to 25 and BDI from 26 to 34 given his fears concerning a second major surgery on the heels of the most recent one. Ms. recommended additional four sessions of individual psychotherapy and four sessions of biofeedback therapy.

According to the utilization review dated June 4, 2010, four sessions of biofeedback therapy were denied with the following rationale: *“The request for four biofeedback therapy sessions is not certified. The clinical documentation indicates the patient has completed four prior sessions of biofeedback to date. Official Disability Guidelines (ODG) recommend continuation of biofeedback therapy with evidence of objective functional improvement with a total of up to 6-10 visits. The clinical documentation fails to indicate the patient has made objective functional improvement with prior treatment. In addition, practice guidelines do not recommend biofeedback as a standalone treatment as an option with a cognitive behavior program. A prior request for the individual psychotherapy was found to be non-certified, given the lack of objective functional improvement. Therefore, biofeedback sessions could not be in-conjunction with a cognitive behavior therapy program. As such, the request for four biofeedback therapy sessions is not certified.”*

On June 29, 2010, Dr. noted pain level of 6/10. Pain was relieved with medications. Examination revealed slowly developing and increasing abduction

of the shoulder, tenderness at the cervicothoracic area and shoulder and slightly improved affect and ROM. Dr. recommended continuing postsurgical regimen from Dr..

Per reconsideration review dated June 30, 2010, request for four biofeedback sessions was denied with the following rationale: *"In an initial mental health evaluation in December 2009 presented with 6-8/10 pain, reduced ADLs, fear of re-injury, severe depression and mild anxiety. Since then received 10 sessions of psychotherapy using a cognitive behavioral approach to mood and pain control. Is applying the behavioral relaxation techniques although there is no documentation of muscle relaxation techniques even though it is a part of the initial treatment plan. He has had four sessions of biofeedback, which appears to be EMG and temperature, but no data was provided to document his response to this care. In addition biofeedback appears to be unnecessary given the lack of basic muscle relaxation training and in fact he is recently postop and is reportedly to have another surgery. Biofeedback is not reasonable or necessary in this case at this time. Discussed with and accepted by Dr."*

In July, Dr. continued medication and ordered a functional capacity evaluation (FCE) after finishing PT. Dr. continued postsurgical regimen and noted that the patient would complete injections at Prime Diagnostics.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS. FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION.

Although ODG recommends a stepped-care approach for treating injured workers, it appears that this approach has already been tried, and has failed. Current request for IT/Bio x4 does not adequately address overall worsening of symptoms when ODG recommended standardized testing instruments are applied. ODG states that additional IT sessions can be requested *with evidence of objective functional improvement*. Additionally, ODG and AMA require antidepressant assessment along with psychotherapy for severely depressed patients. Since patient evidences poor response to treatment, the current request cannot be considered medically necessary.

Cognitive therapy for depression: Recommended. Cognitive behavior therapy for depression is recommended based on meta-analyses that compare its use with pharmaceuticals. Cognitive behavior therapy fared as well as antidepressant medication with severely depressed outpatients in four major comparisons. Effects may be longer lasting (80% relapse rate with antidepressants versus 25% with psychotherapy). ([Paykel, 2006](#)) ([Bockting, 2006](#)) ([DeRubeis, 1999](#)) ([Goldapple, 2004](#)) It also fared well in a meta-analysis comparing 78 clinical trials from 1977 -1996. ([Gloaguen, 1998](#)) In another study, it was found that combined therapy (antidepressant plus psychotherapy) was found to be more effective than psychotherapy alone. ([Thase, 1997](#)) A recent high quality study concluded that a substantial number of adequately treated patients did not respond to antidepressant therapy. ([Corey-Lisle, 2004](#)) A recent meta-analysis concluded that psychological treatment combined with antidepressant therapy is associated with a higher improvement rate than drug treatment alone. In longer therapies, the addition of psychotherapy helps to keep patients in treatment. ([Pampallona, 2004](#)) For panic disorder, cognitive behavior therapy is more effective and more cost-effective than medication. ([Royal Australian, 2003](#)) The gold standard for the evidence-based treatment of MDD is a combination of medication (antidepressants) and psychotherapy. The primary forms of psychotherapy that have been most studied through research are: Cognitive Behavioral Therapy and Interpersonal Therapy. ([Warren, 2005](#))

ODG Psychotherapy Guidelines:

Initial trial of 6 visits over 6 weeks

With evidence of objective functional improvement, total of up to 13-20 visits over 13-20 weeks (individual sessions)

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 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. See the [Pain Chapter](#) for more information and references, as well as ODG biofeedback therapy guidelines. ([van Tulder, 1997](#)) ([Bigos, 1999](#))

MDD treatment, severe presentations: Recommended options as indicated below. Professional standards call for treatment planning to be based on the severity of the presentation of MDD ([American Psychiatric Association, 2006](#)), but the standards do not provide an adequate definition of what is involved in a severe presentation. ([American Psychiatric Association, 2000](#)) Subsequently, this discussion will not have the ability to eliminate the confusion that will be caused by attempts to follow professional standards. A “severe” manifestation is defined as involving most of the diagnostic features for a major depressive episode, and a similarly severe presentation of impairment. ([American Psychiatric Association, 2000](#)) Treatment options:

A. Medication: The American Psychiatric Association strongly recommends anti-depressant medications for severe presentations of MDD, unless electroconvulsive therapy (ECT) is being planned. ([American Psychiatric Association, 2006](#)) The American Psychiatric Association has published additional considerations in regard to various types of anti-depressant medications, and those considerations are summarized in the Procedure Summary, [Antidepressants for treatment of MDD](#) (major depressive disorder). ([American Psychiatric Association, 2006](#))

B. Psychotherapy in combination with medication: The American Psychiatric Association’s standards note that Cognitive behavioral psychotherapy (CBT) may be considered as part of a combined treatment plan for severe presentations of MDD. ([American Psychiatric Association, 2006](#)) The American Psychiatric Association has published additional considerations in regard to various types of psychotherapy, and those considerations are summarized in the Procedure Summary, [Psychotherapy for MDD](#) (Major Depressive Disorder) - *Patient selection*. ([American Psychiatric Association, 2006](#)) Standards call for psychotherapy to be given special consideration **IF** the claimant is experiencing any of the following: (1) significant stressors; (2) internal conflict; (3) interpersonal difficulties/social problems; (4) a personality disorder; & (5) a history of limited/partial response to treatment plans which involved only psychotherapy or only medication. ([American Psychiatric Association, 2006](#))

C. Electroconvulsive therapy: The American Psychiatric Association’s standards endorse electroconvulsive therapy (ECT) as a treatment option for severe manifestations of MDD, presentations which specifically involve acute suicidality, cases in which nutritional compromise has occurred subsequent to the claimant refusing food, cases which involve catatonia, or cases which involve psychosis (psychotic presentations are discussed individually below). ([American Psychiatric Association, 2006](#))

[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](#)) See also [Comorbid psychiatric disorders](#). See also the [Stress/Mental Chapter](#)

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES**

- MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**

- ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**