

<b>Case Number:</b>	CM13-0052876		
<b>Date Assigned:</b>	04/09/2014	<b>Date of Injury:</b>	09/14/2010
<b>Decision Date:</b>	08/12/2014	<b>UR Denial Date:</b>	10/24/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/18/2013

### 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 Anesthesiology, has a subspecialty in Pain Medicine 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:

The patient is a 56-year-old male with a 9/14/10 date of injury, when he lifted a 200 lb object and injured his back. Diagnosis includes posttraumatic back pain of unclear etiology, possibly related to costovertebral arthropathy. 9/30/13 Progress note described chronic mid thoracic spine pain. The patient underwent thoracic facet thermal lesioning that provided some transient post procedure neuritis and only minimally reduced pain. Clinically, there was tenderness to palpation over the right side of the thoracic spine. 10/21/13 Progress note described bilateral thoracic and lumbar paraspinal tenderness from T4 down to S1 with multiple tender trigger points. Repeat facet injections were requested. 3/3/14 Progress note by [REDACTED] described moderate stiffness in the upper and lower back. Clinically, gait was normal; there was diffuse tenderness along the axial spine from the thoracic down to the lumbar area; reduced range of motion in the cervical spine; and positive bilateral SLR. Medications were prescribed.

### IMR ISSUES, DECISIONS AND RATIONALES

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

#### **OUTPATIENT RIGHT COSTOTRANSVERSE INJECTION AT T9 AND T10 UNDER FLUOROSCOPIC GUIDANCE: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation THE OFFICIAL DISABILITY GUIDELINES (ODG).

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) neck and upper back chapter Other Medical Treatment Guideline or Medical Evidence: Thoracic costotransverse joint pain patterns.

**Decision rationale:** This request previously obtained an adverse determination due to lack of guideline support for therapeutic injections for the thoracic region. The patient had prior injections, however no significant response. Within the context of this appeal, this issue was not addressed. Repeat facet injections were requested on 10/21/13. However there remains no discussion of specific response to prior injections or utility of further injections. The request remains unsubstantiated, therefore not medically necessary.