Case Number:	CM15-0103454		
Date Assigned:	06/08/2015	**Date of Injury:**	07/23/2013
Decision Date:	07/09/2015	**UR Denial Date:**	04/30/2015
Priority:	Standard	**Application Received:**	05/29/2015

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: Arizona, Michigan
Certification(s)/Specialty: Preventive Medicine, Occupational 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 57 year old male, who sustained an industrial injury on July 23, 2013. He reported neck pain radiating to bilateral upper extremities, bilateral hand pain and numbness, low back pain radiating to the right buttock and headaches. The injured worker was diagnosed as having gastroesophageal reflux disease, dyspnea, rule out toxic exposure, anxiety, depression, sleep apnea, cervical disc degeneration, intermittent cervical radiculopathy, disc degeneration of the thoracic spine, lumbar strain, cervicogenic and post traumatic headaches and closed head injury. Treatment to date has included diagnostic studies, conservative care, medications and work restrictions. Currently, the injured worker complains of continued neck pain radiating to bilateral upper extremities, bilateral hand pain and numbness, low back pain radiating to the right buttock and headaches. The injured worker reported an industrial injury in 2013, resulting in the above noted pain. He was treated conservatively without complete resolution of the pain. Evaluation on February 3, 2015, revealed continued pain with associated symptoms as noted. It was noted a pulmonology examination was needed to determine the causation of the dyspnea. Evaluation on April 28, 2015, revealed continued pain as noted. Cervical epidural steroid injection and thoracic facet joint blocks were requested.

IMR ISSUES, DECISIONS AND RATIONALES

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

Facet block at T1-2: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines Lumbar & Thoracic (Acute & Chronic) (updated 04/15/15) Facet joint injections, thoracic.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back - Lumbar & Thoracic (Acute & Chronic) / Facet joint injections, thoracic.

Decision rationale: The MTUS / ACOEM did not specifically address the use of thoracic facet blocks and therefore other guidelines were consulted. Per the ODG, it is "not recommended. There is limited research on therapeutic blocks or neurotomies in this region and the latter procedure (neurotomies) are not recommended. Recent publications on the topic of therapeutic facet injections have not addressed the use of this modality for the thoracic region. (Boswell, 2005) (Boswell2, 2005) Pain due to facet joint arthrosis is less common in the thoracic area as there is overall less movement due to the attachment to the rib cage. Injection of the joints in this region also presents technical challenge. A current non-randomized study reports a prevalence of facet joint pain of 42% in patients with chronic thoracic spine pain. This value must be put into perspective with the overall frequency of chronic pain in the cervical, thoracic and lumbar region. In this non-randomized study, 500 patients had 724 blocks. Approximately 10% of the blocks were in the thoracic region, with 35.2% in the cervical region and 54.8% in the lumbar." For regions where facet blocks are recommended, it is recommended that no more than 2 levels be injected and that it not be done at the same time as Epidural Steroid Injections. A review of the injured workers medical records that are available to me do not reveal that the injured worker has exhausted all other first line treatment options that are available and there is nothing in the records that would warrant deviating from the guidelines, therefore based on guideline recommendations the request for Facet blocks in the thoracic region is not medically necessary.

Facet block at T2-3: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines Lumbar & Thoracic (Acute & Chronic) (updated 04/15/15) Facet joint injections, thoracic.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back - Lumbar & Thoracic (Acute & Chronic) / Facet joint injections, thoracic.

Decision rationale: The MTUS / ACOEM did not specifically address the use of thoracic facet blocks and therefore other guidelines were consulted. Per the ODG, it is "not recommended. There is limited research on therapeutic blocks or neurotomies in this region and the latter procedure (neurotomies) are not recommended. Recent publications on the topic of therapeutic facet injections have not addressed the use of this modality for the thoracic region. (Boswell, 2005) (Boswell2, 2005) Pain due to facet joint arthrosis is less common in the thoracic area as there is overall less movement due to the attachment to the rib cage. Injection of the joints in this

region also presents technical challenge. A current non-randomized study reports a prevalence of facet joint pain of 42% in patients with chronic thoracic spine pain. This value must be put into perspective with the overall frequency of chronic pain in the cervical, thoracic and lumbar region. In this non-randomized study, 500 patients had 724 blocks. Approximately 10% of the blocks were in the thoracic region, with 35.2% in the cervical region and 54.8% in the lumbar." For regions where facet blocks are recommended, it is recommended that no more than 2 levels be injected and that it not be done at the same time as Epidural Steroid Injections. A review of the injured workers medical records that are available to me do not reveal that the injured worker has exhausted all other first line treatment options that are available and there is nothing in the records that would warrant deviating from the guidelines, therefore based on guideline recommendations the request for Facet blocks in the thoracic region is not medically necessary.

Facet block at T3-4: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines Lumbar & Thoracic (Acute & Chronic) (updated 04/15/15) Facet joint injections, thoracic.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back - Lumbar & Thoracic (Acute & Chronic) / Facet joint injections, thoracic.

Decision rationale: The MTUS / ACOEM did not specifically address the use of thoracic facet blocks and therefore other guidelines were consulted. Per the ODG, it is "not recommended. There is limited research on therapeutic blocks or neurotomies in this region and the latter procedure (neurotomies) are not recommended. Recent publications on the topic of therapeutic facet injections have not addressed the use of this modality for the thoracic region. (Boswell, 2005) (Boswell2, 2005) Pain due to facet joint arthrosis is less common in the thoracic area as there is overall less movement due to the attachment to the rib cage. Injection of the joints in this region also presents technical challenge. A current non-randomized study reports a prevalence of facet joint pain of 42% in patients with chronic thoracic spine pain. This value must be put into perspective with the overall frequency of chronic pain in the cervical, thoracic and lumbar region. In this non-randomized study, 500 patients had 724 blocks. Approximately 10% of the blocks were in the thoracic region, with 35.2% in the cervical region and 54.8% in the lumbar." For regions where facet blocks are recommended, it is recommended that no more than 2 levels be injected and that it not be done at the same time as Epidural Steroid Injections. A review of the injured workers medical records that are available to me do not reveal that the injured worker has exhausted all other first line treatment options that are available and there is nothing in the records that would warrant deviating from the guidelines, therefore based on guideline recommendations the request for Facet blocks in the thoracic region is not medically necessary.

Facet block at T4-5: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines Lumbar & Thoracic (Acute & Chronic) (updated 04/15/15) Facet joint injections, thoracic.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back - Lumbar & Thoracic (Acute & Chronic) / Facet joint injections, thoracic.

Decision rationale: The MTUS / ACOEM did not specifically address the use of thoracic facet blocks and therefore other guidelines were consulted. Per the ODG, it is "not recommended. There is limited research on therapeutic blocks or neurotomies in this region and the latter procedure (neurotomies) are not recommended. Recent publications on the topic of therapeutic facet injections have not addressed the use of this modality for the thoracic region. (Boswell, 2005) (Boswell2, 2005) Pain due to facet joint arthrosis is less common in the thoracic area as there is overall less movement due to the attachment to the rib cage. Injection of the joints in this region also presents technical challenge. A current non-randomized study reports a prevalence of facet joint pain of 42% in patients with chronic thoracic spine pain. This value must be put into perspective with the overall frequency of chronic pain in the cervical, thoracic and lumbar region. In this non-randomized study, 500 patients had 724 blocks. Approximately 10% of the blocks were in the thoracic region, with 35.2% in the cervical region and 54.8% in the lumbar." For regions where facet blocks are recommended, it is recommended that no more than 2 levels be injected and that it not be done at the same time as Epidural Steroid Injections. A review of the injured workers medical records that are available to me do not reveal that the injured worker has exhausted all other first line treatment options that are available and there is nothing in the records that would warrant deviating from the guidelines, therefore based on guideline recommendations the request for Facet blocks in the thoracic region is not medically necessary.

Cervical epidural steroid injection at C5-6: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines-Treatment in Workers' Compensation Low Back Lumbar & Thoracic (Acute & Chronic) Epidural Steroid Injections (ESIs), therapeutic.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injections Page(s): 46. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and Upper Back (Acute & Chronic) / Epidural Steroid Injections (ESI).

Decision rationale: Per the MTUS, Cervical Epidural steroid injections are not recommended; there is insufficient evidence to make any recommendation for the use of epidural steroid injections to treat radicular cervical pain. Per the ODG, also not recommended based on recent evidence, given the serious risks of this procedure in the cervical region, and the lack of quality evidence for sustained benefit. These had been recommended as an option for treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy), with specific criteria for use described in the ODG and should not be performed at levels higher than C6-7. A review of the injured workers medical records that are available to me do not reveal that the injured worker has exhausted all other less risky first line treatment options that are available and there is nothing in the records that would warrant deviating from

the guidelines, therefore based on guideline recommendations the request for Cervical epidural steroid injection at C5-6 is not medically necessary.

Cervical epidural steroid injection at C6-7: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines-Treatment in Workers' Compensation Low Back Lumbar & Thoracic (Acute & Chronic) Epidural Steroid Injections (ESIs), therapeutic.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injections Page(s): 46. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and Upper Back (Acute & Chronic) / Epidural Steroid Injections.

Decision rationale: Per the MTUS, Cervical Epidural steroid injections are not recommended; there is insufficient evidence to make any recommendation for the use of epidural steroid injections to treat radicular cervical pain. Per the ODG, also not recommended based on recent evidence, given the serious risks of this procedure in the cervical region, and the lack of quality evidence for sustained benefit. These had been recommended as an option for treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy), with specific criteria for use described in the ODG and should not be performed at levels higher than C6-7. A review of the injured workers medical records that are available to me do not reveal that the injured worker has exhausted all other less risky first line treatment options that are available and there is nothing in the records that would warrant deviating from the guidelines, therefore based on guideline recommendations the request for Cervical epidural steroid injection at C6-7 is not medically necessary.