

<b>Case Number:</b>	CM15-0202205		
<b>Date Assigned:</b>	10/21/2015	<b>Date of Injury:</b>	09/22/2014
<b>Decision Date:</b>	12/03/2015	<b>UR Denial Date:</b>	09/09/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/14/2015

### 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: Family Practice

### CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This injured worker is a 45 year old male, who sustained an industrial injury on 09-22-2014. The injured worker was diagnosed as having rotator cuff tear. On medical records dated 06-02-2015, the subjective complaints were noted as right shoulder pain, stiffness and locking. Pain is located in the biceps and scapular aspect. Objective findings were noted as cervical spine revealed tender tenderness in the paraspinal muscles. Thoracic spine revealed appears straight, normal range of motion was noted, stability-strength appear within normal limits and no abnormalities noted. Treatments to date included medication, physical therapy and activity restrictions. MRI of the thoracic spine without contrast performed on 05-20-2015 revealed anterior endplate corner marrow changes from T7-T8 to T9-T10. Otherwise unremarkable thoracic spine MRI. No significant posterior disc pathology, spinal canal or neuroforaminal stenosis. No nerve impingement and no fracture or listhesis. The injured worker was noted to be temporarily totally disabled. Current medications were listed as Metformin HCL and Lisinopril 2.5mg. The Utilization Review (UR) was dated 09-09-2015. A Request for Authorization was submitted. The UR submitted for this medical review indicated that the request for right T7, T8, T9 rib facet injections was non-certified.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Right T7, T8, T9 rib facet injections: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chapter: Low Back Section: Facet Joint Pain/Signs and Symptoms.

**Decision rationale:** The Official Disability Guidelines comment on the use of facet injections. It is recommended that a thorough patient history be obtained to exclude alternative etiologies of pain (particularly radiculopathies). Mechanism of injury: The cause of this condition is largely unknown, but suggested etiologies have included microtrauma, degenerative changes, and inflammation of the synovial capsule. The overwhelming majority of cases are thought to be the result of repetitive strain and/or low-grade trauma accumulated over the course of a lifetime. Less frequently, acute trauma is thought to be the mechanism, resulting in tearing of the joint capsule or stretching beyond physiologic limits. Osteoarthritis of the facet joints is commonly found in association with degenerative joint disease. Physical exam findings & symptoms: As most examinations simultaneously test several structures including muscles, ligaments, discs and facets, there is no suggested physical maneuver or tests to effectively diagnose facet joint mediated pain. Axial low back pain is generally present with lumbar paravertebral tenderness. There is no reliable pain referral pattern other than that pain is pseudoradicular. It is suggested that pain from upper facet joints tends to extend to the flank, hip and upper lateral thighs, while the lower joint mediated pain tends to penetrate deeper into the thigh (generally lateral and posterior). Infrequently, pain may radiate into the lateral leg or even more rarely into the foot, although multiple references indicate pain distal to the knee is rarely associated with facet joint pathology. In the presence of osteophytes, synovial cysts (diagnosed with MRI) or facet hypertrophy (diagnosed on imaging), radiculopathy may also be present. In patients with these latter conditions, injection therapy will generally not alleviate pain that originates primarily from the anterior or posterior ligaments or bone. Some studies have suggested that the presence of the following were helpful in identifying patients with this condition: (1) age > 65; (2) pain relieved when supine; (3) no increase in pain with coughing, hyperextension, forward flexion, rising from flexion or extension/rotation. Recent research has corroborated that pain on extension and/or rotation (facet loading) is a predictor of poor results from neurotomy, but in general, previous and subsequent studies have failed to corroborate these findings. Radiographic findings: There is no support in the literature for the routine use of imaging studies to diagnose lumbar facet mediated pain. Studies have been conflicting in regards to CT and/or MRI evidence of lumbar facet disease and response to diagnostic blocks or neurotomy. Degenerative changes in facets identified by CT do not correlate with pain and are part of the natural degenerative process. Differential diagnosis: Other causes of predominately axial low back pain must be considered in the differential diagnosis including discogenic pain, sacroiliac joint pathology, ligamentous injury, and myofascial pain. Within the context of facet pathology, inflammatory arthritis should be considered as a differential diagnosis. Conditions include rheumatoid arthritis, ankylosing spondylitis, gout, psoriatic arthritis, reactive arthritis (and other spondyloarthropathies) as well as osteoarthritis and synovitis. Suggested indicators of pain related to facet joint pathology (acknowledging the contradictory findings in current research):(1) Tenderness to palpation in the paravertebral areas (over the facet region);(2) Predominate axial low back pain;(3) Absence of radicular findings in a dermatomal distribution, although pain may radiate below the knee. In this case, there is insufficient information provided to justify the diagnosis of a facet syndrome. There is insufficient information in the patient's history or physical examination findings. Further, there is no evidence that other etiologies for the patient's thoracic pain have been assessed. For these reasons, R T7-T9 rib facet injections are not medically necessary.

