

Case Number:	CM15-0048527		
Date Assigned:	03/20/2015	Date of Injury:	02/20/2013
Decision Date:	05/01/2015	UR Denial Date:	02/24/2015
Priority:	Standard	Application Received:	03/13/2015

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: Pennsylvania

Certification(s)/Specialty: Internal Medicine, Hospice & Palliative 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 40 year old male who sustained an industrial injury on 2/20/13. The injured worker reported symptoms in the back and right upper extremity. The injured worker was diagnosed as having displacement thoracic disc without myelopathy. Treatments to date have included oral pain medication, ice, chiropractic treatment, physical therapy, epidural injection, and activity modification. Currently, the injured worker complains of pain in the back and right upper extremity. The plan of care was for a facet joint injection.

IMR ISSUES, DECISIONS AND RATIONALES

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

Bilateral thoracic facet joint injection, T7-8 and T8-9: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG-TWC).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 12 Low Back Complaints Page(s): 174 and 181, page(s) 300 and 307.

Decision rationale: The ACOEM Guidelines do not support the use of facet injections in the treatment of acute or chronic neck, upper, or lower back pain. While some clinicians believe this treatment has some short-term benefit for those in the transition period between acute and chronic pain, there are no good studies to support this claim. The submitted and reviewed documentation indicated the worker was experiencing pain in the right arm and mid-back. There was no discussion describing special circumstances that sufficiently supported this request. In the absence of such evidence, the current request for facet injections at both sides of the T7 and T8 levels of the mid-back region with fluoroscopic guidance and sedating medication given intravenously is not medically necessary.

Intravenous (IV) sedation: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG-TWC).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints, Chapter 8 Neck and Upper Back Complaints Page(s): 174 and 181, page(s) 300 and 307.

Decision rationale: The ACOEM Guidelines do not support the use of facet injections in the treatment of acute or chronic neck, upper, or lower back pain. While some clinicians believe this treatment has some short-term benefit for those in the transition period between acute and chronic pain, there are no good studies to support this claim. The submitted and reviewed documentation indicated the worker was experiencing pain in the right shoulder and hand and in the lower back, knee locking, and heartburn. There was no discussion describing special circumstances that sufficiently supported this request. In the absence of such evidence, the current request for facet injections at both sides of the T7 and T8 levels of the mid-back region is not medically necessary. Therefore, the fluoroscopic guidance and sedating medication given intravenously is not medically necessary.

Fluoroscopic guidance: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG-TWG).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 12 Low Back Complaints Page(s): 174 and 181, page(s) 300 and 307.

Decision rationale: The ACOEM Guidelines do not support the use of facet injections in the treatment of acute or chronic neck, upper, or lower back pain. While some clinicians believe this treatment has some short-term benefit for those in the transition period between acute and chronic pain, there are no good studies to support this claim. The submitted and reviewed documentation indicated the worker was experiencing pain in the right shoulder and hand and in the lower back, knee locking, and heartburn. There was no discussion describing special circumstances that sufficiently supported this request. In the absence of such evidence, the current request for facet injections at both sides of the T7 and T8 levels of the mid-back region is

not medically necessary. Therefore, the fluoroscopic guidance and sedating medication given intravenously is not medically necessary.