

Case Number:	CM14-0004568		
Date Assigned:	02/05/2014	Date of Injury:	02/09/2011
Decision Date:	07/02/2014	UR Denial Date:	01/08/2014
Priority:	Standard	Application Received:	01/13/2014

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 Occupational 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 61-year-old male who has submitted a claim for lumbar radiculopathy status post posterior lumbar interbody fusion at L4-L5 associated with an industrial injury date of February 9, 2011. Medical records from 2012-2013 were reviewed, the latest of which dated December 18, 2013 revealed that the patient presents with low back pain with symptoms into his lower extremities that he rates 6-7/10. He continues to have bilateral lower extremity complaints with symptoms to the foot that is greater on the left side. He gets up and moves around throughout the day. The medications do help with his pain level and allow for an increased level of function. He denies side effects to these medications. On physical examination, patient has an antalgic gait. The lumbar surgical site is clean, dry and intact. He has difficulty rising from a seated position. He has diffuse tenderness over the lumbar spine with spasm noted. He has left sciatic notch tenderness. He has decreased sensation in the left L4 dermatome. Motor strength of the quadriceps, hamstrings, and tibialis anterior, extensor hallucis longus, inversion and eversion are 4+/5 on the left. He has a positive straight leg raising test on the left with "heat" into the calf region at 45 degrees. Lumbar spine x-ray done last June 17, 2013 revealed slight halo around the L5 hardware. CT scan of the lumbar spine done last September 9, 2013 revealed status post L4-L5 instrumentation without apparent complication. There is moderate right L5-S1 foraminal stenosis. Treatment to date has included posterior lumbar interbody fusion at L4-L5 (11/8/12), TLSO brace, home exercise program, and medications which include Norco, Flexeril, Percocet, and Zanaflex. Utilization review from January 8, 2014 denied the request for full body bone scan because there is no evidence of possible pseudoarthrosis and infection or fracture.

IMR ISSUES, DECISIONS AND RATIONALES

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

FULL BODY SCAN: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation . Medical Evidence: Nuclear Medicine, full body bone scan online version.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter, CRPS, diagnostic tests, Bone scanX Other Medical Treatment Guideline or Medical Evidence: aetna-health.healthline/smartsources/healthwisecontent/medicaltest.

Decision rationale: The CA MTUS does not specifically address the topic on bone scan or full body scans. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers Compensation, the Official Disability Guidelines (ODG), Pain Section, was used instead. ODG states that diagnostic tests like bone scan are recommended assessment of clinical findings as the most useful method of establishing the diagnosis. Bone scans have been suggested for use as additional tools for diagnosis, with use based on the patient's medical presentation. It is recommended for select patients in early stages to help in confirmation of the diagnosis. Routine use is not recommended. In addition, Aetna Clinical Policy Bulletin recommends bone scan done to diagnose the cause or location of unexplained bone pain; and to determine the location of an abnormal bone in complex bone structures. In this case, full body bone scan was requested to rule out pseudoarthrosis due to a potential lucency of the hardware. However, a CT scan of the lumbar spine done last September 9, 2013 does not support such findings. There is no progression of symptoms or recent injury that warrants further investigation. The medical necessity of full body bone scan was not established. Therefore, the request for full body bone scan is not medically necessary.