

Case Number:	CM14-0104256		
Date Assigned:	07/30/2014	Date of Injury:	03/03/2008
Decision Date:	09/24/2014	UR Denial Date:	06/30/2014
Priority:	Standard	Application Received:	07/07/2014

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 Family 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:

This is a 54 year old female with a 3/3/06 injury date. She sustained an industrial injury while she was lifting a case of water while at work, injuring her neck and back. In a follow-up on 5/30/14, subjective complaints were low back pain with aching, stabbing, and tingling pain in the mid right lower back that radiates to right buttock, hip, and lower extremities to the feet, severity 8/10. Sitting increases the symptoms. The back pain is much worse than the leg pain. Objective findings include antalgic gait, limited lumbar extension, and tenderness to palpation in the lumbar facet regions, decreased sensation at L4, L5, and S1 dermatomes on the left. There is 4+/5 strength bilaterally at the tibialis anterior, EHL, inversion, and eversion and limited by pain. There is 5-/5 strength bilaterally at the quadriceps and hamstrings. A CT of the lumbar spine on 8/23/13 showed interval development of a 5 mm anterolisthesis of L4 on L5 due to bilateral pars defects of L4, stable postsurgical changes which include interbody fusions of L3-4, pedicle screw fixation from L2 to L4 and laminectomies of L4 and L5, and the fusion appears intact. There were stable multilevel degenerative changes of the lumbar spine with mild to moderate neural foraminal narrowing at multiple disc levels without spinal canal stenosis. Diagnostic impression: lumbar spondylosis s/p lumbar fusion. Treatment to date: L3-4 discectomy with lumbar fusion L2-5 (4/23/07), revision fusion at L2-3 and L3-4 (1/19/10), lumbar facet medial branch blocks at L4-5 (1/10/14), medication management. A UR decision on 6/30/14 denied the request for bone scan on the basis that a recent CT scan indicated that the fusion was intact, with no evidence of pseudoarthrosis.

IMR ISSUES, DECISIONS AND RATIONALES

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

Bone scan to further evaluate for Pseudoarthrosis: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): Table 12-8, page 309. Decision based on Non-MTUS Citation ODG Guidelines Low Back-Lumbar and Thoracic (Acute and Chronic).

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 Chapter.

Decision rationale: CA MTUS does not address this issue. ODG does not recommend bone scanning, except for bone infection, cancer, or arthritis. Bone scans use intravenous administration of tracer medications to show radioactive uptake to detect metastases, infection, inflammatory arthropathies, significant fracture, or other significant bone trauma. In the present case, the most recent CT lumbar spine clearly showed a solid fusion. Therefore, the request for bone scan to further evaluate for pseudoarthrosis is not medically necessary.