

<b>Case Number:</b>	CM14-0063847		
<b>Date Assigned:</b>	07/11/2014	<b>Date of Injury:</b>	03/28/2000
<b>Decision Date:</b>	09/12/2014	<b>UR Denial Date:</b>	04/18/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/06/2014

### 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 Physical Medicine and Rehabilitation 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 injured worker is a 45-year-old male who reported injury on 03/28/2000, reportedly, while he was painting he fell 2 stories off the roof landing on a concrete driveway. He sustained injuries to the pelvis, left wrist, and left index and ring fingers. The injured worker's treatment history included medications, MRI, EMG/NCV, CT scan, surgery, and epidural injections. Within the documentation submitted, the injured worker had an open reduction internal fixation of the left wrist with carpal tunnel release and a right shoulder rotator cuff repair in 2000. He did have chronic pelvic pain. The injured worker had undergone a CT scan of the pelvis on 11/18/2013 and it was documented that the injured worker had a 5.6 mm lucent and mildly extensive lesion within the superior pubic ramus. A very small focus of cortical breakthrough was noted about the posterior lateral margin of the lesion. There was a prominent left L5 transverse process, which could be related to transitional anatomy with a partial sacralization. There was an old fracture of the left inferior pubic ramus and an old fracture of the right inferior pubic ramus. No avascular necrosis was noted. The injured worker had undergone MRI of the lumbar spine dated 12/05/2012 that revealed a mild disc bulge at L2-3 with a small component of extrusion to the right neural foramen and mild facet DJD. Mild broad based disc bulging with annular tearing was noted at L3-4 with a small left paramedian extrusion. Mild left lateral recess stenosis was noted. At L4-5 there was mild broad based disc bulge with annular tear and mild left lateral recess stenosis. L5-S1 was unremarkable. The injured worker was evaluated on 06/05/2014, it was documented that the injured worker complained of chronic pelvic pain. The provider noted the injured worker has not had any therapy. He does a home exercise program. An extended history of present illness greater than 4 elements occurred. The injured worker's pain was 6/10 to 7/10 in the right shoulder and lower back. There were no complaints of significant radicular symptoms in the lower extremities. He continued to have pain in the wrist

and uses wrist braces. Physical examination was unchanged. Medications included Voltaren gel, Ultram 50 mg, and Lortab. Diagnoses included fracture left wrist status post open reduction internal fixation with carpal tunnel release and post traumatic arthritis, chronic wrist pain, chronic bilateral shoulder pain status post-surgery on the right with limited range of motion, chronic lower back pain with degenerative disc and annular tears L3-4 and L4-5, transitional lumbar vertebra with facet arthritis L3-4 and L4-5, pelvic fractures with chronic pelvic and hip pain, and left inguinal hernia. Within the documentation submitted, the provider noted a CT scan with a plain x-ray with multiplanar reformatting. Clearly, there was no need for plain x-ray if a CT scan has been done. Request for Authorization was not submitted for this review. The rationale for the bone scan of the pelvis and lumbar spine was for an extended history of present illness greater than 4 elements occurred. Pertinent other history greater than 2 areas occurred. The rationale for the discogram was for to confirm if the injured worker pain was coming from discs in back.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

#### **Bone Scan for Pelvis and Lumbar Spine: 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), Hip & Pelvis (updated 03/25/2014), Bone Scan.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Bone Scan, Hip & Pelvis & Low Back & Thoracic.

**Decision rationale:** According to Official Disability Guidelines (ODG) bone scans on the pelvis are recommended in the presence of normal radiographs, and in the absence of ready access to MR imaging capability. Radionuclide bone scans are effective for detection of subtle osseous pathology and, when negative, are useful in excluding bone or ligament/tendon attachment abnormalities. Bone scanning is more sensitive but less specific than MRI. It is useful for the investigation of trauma, infection, stress fracture, occult fracture, Charcot joint, Complex Regional Pain Syndrome, and suspected neoplastic conditions of the lower extremity. Although the diagnostic performance of the imaging techniques (Plain radiography, arthrography, and bone scintigraphy) was not significantly different, plain radiography and bone scintigraphy are preferred for the assessment of a femoral component because of their efficacy and lower risk of patient morbidity. Bone scans of the lumbar spine are not recommended, except for bone infection, cancer, or arthritis. [Note: This is different from the 1994 AHCPR Low Back Guideline, which said "Recommend if no improvement after 1 month" for Bone scan.] 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. The provider failed to indicate the injured worker's failed conservative measures. It was noted the injured has not had any therapies however, the documents submitted indicated the injured has had prior physical therapy. Given the above, the request for Bone Scan for Pelvis and Lumbar Spine is not medically necessary and appropriate.

**Discogram L3-L4, L4-L5 and L5-S1: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Bone Scan.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-305.

**Decision rationale:** According to the California MTUS/ACOEM guidelines state that discogram Lumbar spine x rays should not be recommended in patients with low back pain in the absence of red flags for serious spinal pathology, even if the pain has persisted for at least six weeks. However, it may be appropriate when the physician believes it would aid in patient management. Recent studies on diskography do not support its use as a preoperative indication for either intradiskal electrothermal (IDET) annuloplasty or fusion. Diskography does not identify the symptomatic high intensity zone, and concordance of symptoms with the disk injected is of limited diagnostic value (common in non-back issue patients, inaccurate if chronic or abnormal psychosocial tests), and it can produce significant symptoms in controls more than a year later. Tears may not correlate anatomically or temporally with symptoms. Diskography may be used where fusion is a realistic consideration, and it may provide supplemental information prior to surgery. This area is rapidly evolving, and clinicians should consult the latest available studies. Despite the lack of strong medical evidence supporting it, diskography is fairly common, and when considered, it should be reserved only for patients who meet the following criteria: Back pain of at least three months duration. Failure of conservative treatment. Satisfactory results from detailed psychosocial assessment. (Diskography in subjects with emotional and chronic pain problems has been linked to reports of significant back pain for prolonged periods after injection, and therefore should be avoided.). Has been briefed on potential risks and benefits from diskography and surgery. The provider failed to indicate the injured worker's failed conservative measures. It was noted the injured has not had any therapies however, the documents submitted indicated the injured has had prior physical therapy. Additionally, the documents submitted failed to indicate if the injured worker was a candidate for surgery. Given the above, the request for Discogram for L3-L4, L4-L5 and L5-S1 is not medically necessary and appropriate.