

Case Number:	CM14-0078820		
Date Assigned:	07/18/2014	Date of Injury:	08/19/2002
Decision Date:	09/08/2014	UR Denial Date:	05/20/2014
Priority:	Standard	Application Received:	05/29/2014

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 Neurology, has a subspecialty in Neuromuscular Medicine, and is licensed to practice in New Jersey. 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 51-year-old woman who sustained a work-related injury on 08/19/2002. Subsequently, she developed chronic neck pain with numbness in the fingers of both hands. A right shoulder MRI dated 12/23/2009 showed biceps tendinosis and joint effusion. A cervical MRI dated 12/23/2009 showed spondylosis with mild encroachment on the foramina at C4-5 and C5-6. An EMG (electromyography) of the right upper extremity showed no evidence of neuropathy at the elbow or of cervical radiculopathy. According to a note dated 04/29/2014, the patient was complaining of left greater than right shoulder, arm, and hand pain. She also has new lower back pain. The pain is moderate to severe in intensity. The patient previously underwent a right intra-articular shoulder injection with 95% relief which reportedly lasted for one hour. Physical examination revealed a stiff neck. There was pain with flexion and extension, as well as with right and left rotation, of the cervical spine. There was tenderness to palpation of the lumbar spine, with pain on flexion and extension as well as right and left rotation. There was tenderness to palpation of the cervical paraspinal region. Her gait was normal. Straight leg raise was negative bilaterally. Sensation was diminished in the C8 dermatome bilaterally. The treatment history indicates no failed treatments and no failed medications. The provider requested authorization for SPECT CT of the cervical spine.

IMR ISSUES, DECISIONS AND RATIONALES

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

SPECT CT of the Cervical 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-Low Back.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck and Upper Back (Acute & Chronic), Bone Scan (see <http://www.worklossdatainstitute.verioiponly.com/odgtwc/neck.htm>).

Decision rationale: According to ODG, cervical spine SPECT scan is not recommended except as an option in follow-up evaluation of osseous metastases. This recommendation is based on evidence more current than the 1994 AHCPR Guideline, which had recommended this procedure for neck pain with no improvement after one month. Radionuclide bone scanning should not be the initial procedure of choice for patients with chronic neck pain, regardless of the etiology, including trauma, arthritis, or neoplasm. (Spitzer, 1995) (Daffner, 2010) For follow-up evaluation of osseous metastatic disease in malignant or aggressive musculoskeletal tumors, the Tc-99m bone scan of the whole body is a useful screening tool; but in cases of abnormal spine uptake, SPECT/CT can be used to better distinguish metastases from degenerative changes. There is a paucity of recent literature regarding whole-body bone scan and screening for osseous metastases. Much of this likely relates to recent advances in FDG-PET/CT and whole-body MRI and their superior anatomic resolution and specificity. Nonetheless, whole-body bone scan remains a useful screening tool in osseous metastatic disease, with an overall sensitivity comparable to that of FDG-PET/CT. In cases where there is abnormal radiotracer uptake in the spine, SPECT/CT can be used to better distinguish metastases from degenerative changes, thus increasing specificity. (Fitzgerald, 2011) A bone scan is an imaging test intended to detect increased activity in bone, such as fractures, infections, inflammation, or tumors (benign or malignant), by detecting changes in function before structural changes occur. There is no clear rationale for the request for a cervical SPECT scan. There is no documentation that a metastatic disease of the cervical spine, versus degenerative disc disease, is in the differential diagnosis in this patient. Furthermore, there is no documentation of resistance to pain medication that may require special investigation into other causes of pain for this patient. Therefore, the request for cervical SPECT scan is not medically necessary.