

Case Number:	CM14-0170751		
Date Assigned:	10/23/2014	Date of Injury:	02/16/2010
Decision Date:	02/27/2015	UR Denial Date:	10/06/2014
Priority:	Standard	Application Received:	10/15/2014

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. 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: California

Certification(s)/Specialty: Physical Medicine & Rehabn

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 53 year old female with an injury date on 2/16/10. The patient complains of persistent pain and worsening cervical range of motion per 9/29/14 report. The patient is more than a year out from a cervical anterior fusion done from C3 to C5, and an MRI scan showed interval change and adjacent segment stenosis at C5-6 per 9/29/14 report. The patient initially felt improvement in her neck/radiating arm pain after the surgery per 8/18/14 report. The patient has mild numbness/tingling into the right thumb, index, and long finger of the right hand per 9/29/14 report. Based on the 9/29/14 progress report provided by the treating physician, the diagnosis is adjacent level disc herniation at C5-6 with remote fusion from C3 to C5. A physical exam on 9/29/14 showed significantly restricted cervical range of motion and tenderness at C5-6. Very positive spurling sign bilaterally. The patient's treatment history includes medications, physical therapy, MRI L-spine, MRI C-spine, cervical epidural steroid injection. The treating physician is requesting DEXA scan of unspecified body part per 9/26/14 report. The utilization review determination being challenged is dated 10/6/14 and denies request due to lack of evidence that DEXA scans are shown to be clinically reliable. The requesting physician provided treatment reports from 11/4/13 to 12/17/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

DEXA scan of unspecified body part, per 09/26/14 report: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation <http://www.ncbi.nlm.nih.gov> Dual-energy X-ray absorptiometry and body composition, Laskey MA

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Knee/Leg Chapter, Bone densitometry

Decision rationale: This patient presents with neck pain. The treater has asked for DEXA SCAN OF UNSPECIFIED BODY PART PER 9/26/14 REPORT but the requesting progress report is not included in the provided documentation. A cervical MRI dated 7/15/14 showed at C5-6, there is a central to left paracentral disc osteophyte complex at 5-6mm with mild flattening of the spinal cord centrally with AP diameter of cord reduced 8 to 9mm consistent with mild stenosis and severe stenosis of the right lateral recess and right neural foramen noted due to the large paracentral disc osteophyte. There has been an interval change in the disc herniation at C5-6 suggestive of the adjacent level process with new soft tissue component to a degenerative spondylotic change per 9/29/14 report. The original C-spine MRI was not included in documentation. Regarding bone densitometry, ODG states it is recommended for selected patients to determine whether osteoporosis is present in individuals of appropriate age and risk factors having an injury including a fracture. ODG states: "Osteoporosis does not appear to have a direct causal relationship to work injury or work exposures, so authorization of services for diagnosis or treatment of osteoporosis should not be commonly considered or approved in workers' comp. It may be appropriate to monitor for osteoporosis in individuals (usually with Bone Density Measurements or DEXA scans) who are being treated for other conditions if that condition or the treatment of the condition is associated with the development of osteoporosis, for example, monitoring of an individual who is of appropriate age and treated for a condition with prednisone at doses greater than 7.5 mg per day for more than 3 months. These decisions should be made on a case by case basis. Due to the long term nature, treatment of osteoporosis should require an additional agreed upon allowance on a claim. If a claim is allowed for osteoporosis, appropriate treatment would include medication and monitoring as recommend by guidelines such as those from the National Osteoporosis Foundation." In this case, the patient has radicular symptoms in the neck/upper extremity. An MRI showed significant herniation at C5-6 with some degenerative spondylotic change. The treater has requested bone densitometry which may be appropriate for patients of a certain age with risk factors for injury such as a fracture from osteoporosis. However, the patient is 52 years of age and does not appear to present with osteoporosis, or other condition for which a Dexascan would be needed. ODG also clarifies that osteoporosis is a non-injury issue. The request IS NOT medically necessary.