

<b>Case Number:</b>	CM14-0188017		
<b>Date Assigned:</b>	11/18/2014	<b>Date of Injury:</b>	09/05/2012
<b>Decision Date:</b>	01/06/2015	<b>UR Denial Date:</b>	10/07/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/11/2014

### 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 47-year-old male who has submitted a claim for lumbar disc herniation, lumbar disc degeneration and radiculopathy associated with an industrial injury date of 9/5/2012. Medical records from 2013 to 2014 were reviewed. The patient complained of persistent low back pain despite surgery. Physical examination showed an antalgic gait, patient in acute distress, limited lumbar motion, and grossly intact motor and coordination. MRI of the lumbar spine, dated 10/9/2013, demonstrated posterior disc protrusion at L4-L5. There was a right laminectomy at L5-S1. There was scar tissue around the right side at L5-S1 without evidence of recurrent residual disc. Treatment to date has included lumbar fusion in April 2014, prior laminectomy and discectomy at L5-S1 in July 2013, physical therapy, Effexor, Zanaflex, and Norco. The documented rationale for a bone scan is to rule out discitis. The utilization review from 10/7/2014 denied the request for one (1) nuclear medicine white blood cell count because the documented rationale for the request was to rule out discitis. However, the guidelines only recommended the procedure for detecting the presence of infection and not for specifying the diagnosis.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**One (1) nuclear medicine white blood cell count:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACR Appropriateness Criteria Low Back Pain, Reston (VA), American College of Radiology (ACR), 2011. 8 page, Isotope Bone Scan.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Discitis, Radiology Source

**Decision rationale:** The CA MTUS does not specifically address this topic. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers Compensation, and the Radiology Source was used instead. The most common laboratory abnormalities in patients with discitis are an elevated erythrocyte sedimentation rate (ESR) and elevated levels of C-reactive protein (CRP), seen in over 90% of patients. Leukocytosis is not consistently present, occurring in less than 50% of patients; therefore a normal white blood cell count does not exclude discitis. Gallium scans and technetium-99M scans are highly sensitive for the detection of discitis, with positive scans seen in 90% of patients that have been symptomatic for longer than 2 days. The increased uptake in the affected endplates and decrease in disc space height produces a characteristic "sandwich" appearance. However, because of the poor anatomic resolution of nuclear medicine studies and the advent of more sensitive and specific imaging modalities, these studies are usually utilized in cases of fever of unknown origin or, in the case of gallium scan, as part of treatment follow-up. Technetium-99m scans remain positive long after healing has occurred, and are thus not useful in assessing treatment efficacy. In this case, the patient complained of persistent low back pain despite surgery. Physical examination showed an antalgic gait, patient in acute distress, limited lumbar motion, and grossly intact motor and coordination. MRI of the lumbar spine, dated 10/9/2013, demonstrated posterior disc protrusion at L4-L5. There was a right laminectomy at L5-S1. There was scar tissue around the right side at L5-S1 without evidence of recurrent residual disc. The documented rationale for a bone scan is to rule out discitis. However, there is no supporting discussion why the condition is being considered. Progress report submitted is handwritten and somewhat illegible. There is likewise no objective data that may corroborate presence of discitis. The medical necessity cannot be established due to insufficient information. Therefore, the request for one (1) nuclear medicine white blood cell count is not medically necessary.