

Case Number:	CM15-0239134		
Date Assigned:	12/16/2015	Date of Injury:	06/28/1982
Decision Date:	01/25/2016	UR Denial Date:	11/20/2015
Priority:	Standard	Application Received:	12/07/2015

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, District of Columbia, Maryland
 Certification(s)/Specialty: Anesthesiology, Pain Management

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 54 year old male, who sustained an industrial injury on June 28, 1982. The injured worker was diagnosed as having mid-thoracic pain with anterior calcifications. Treatment and diagnostic studies to date has included medication regimen, x-rays of the thoracic spine, physical therapy, x-rays of the cervical spine, magnetic resonance imaging of the right brachial plexus, and cardiology evaluation and treatment. In a progress note dated November 06, 2015 the treating physician reports complaints of pain to the mid-thoracic region with bilateral leg pain to the knees. Examination performed on November 06, 2015 was revealing for pain to the low back with supine straight leg raises. On November 06, 2015 the treating physician noted x-rays with the date not noted that was revealing for "calcification noted anteriorly at the level of proximally thoracic 9 etiology of it uncertain." The documentation provided did not indicate that prior bone scans were performed. On November 06, 2015 the treating physician requested 1 whole body bone scan "to see if there is significant uptake at that level associated with the calcification." On November 20, 2015 the Utilization Review determined the request for 1 whole body bone scan to be non-certified.

IMR ISSUES, DECISIONS AND RATIONALES

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

Whole body bone scan: Overturned

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, Bone scan; National Guideline Clearinghouse.

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, Bone Scan.

Decision rationale: The MTUS CPMTG is silent on bone scan. Per the ODG guidelines regarding bone scan: 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. Upon review of the submitted records, it was noted per progress report dated 11/6/15 that the provider noted x-rays revealed "calcification noted anteriorly at the level of proximally thoracic 9 etiology of it uncertain." I respectfully disagree with the UR physician's assertion "there was no indication that the provider suspected cancer, infection, fracture, inflammatory arthritis, or immunosuppression." Per the citation above, "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." The request is medically necessary.