

Case Number:	CM13-0004353		
Date Assigned:	03/12/2014	Date of Injury:	01/01/2008
Decision Date:	04/14/2014	UR Denial Date:	07/05/2013
Priority:	Standard	Application Received:	07/29/2013

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 Preventive 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:

According to the records made available for review, this is a 52-year-old male with a 1/1/08 date of injury. At the time (6/24/13) of request for authorization for whole body bone scan for lumbar spine, there is documentation of subjective (severe pain in his back down to his right leg that is so severe the patient feels he cannot work and feels it is getting worse) and objective (not specified) findings, imaging findings (MRI Lumbar Spine (9/18/12) report revealed multilevel spondylosis most pronounced at L4-5 level where there is moderate central canal stenosis and moderate bilateral facet joint and ligamentum flavum hypertrophy; and degenerative neural foraminal narrowing is noted in the L3-4 through L5-S1 levels), current diagnoses (chronic low back pain), and treatment to date (activity modification, epidural steroid injection, and medications (Ibuprofen and Vicodin)). Discussion identifies a recommendation for a bone scan to rule out any other problems and see if it lights up at L4-5. Medical report identifies that the epidural steroid injection did not give him much relief. 6/19/13 medical report identifies that on physical examination, the patient's motion is slow, gait is slow, and his back is very limited. There is no documentation of a diagnosis/condition (with supportive subjective/objective findings) for which a bone scan is indicated (bone infection, cancer, or arthritis).

IMR ISSUES, DECISIONS AND RATIONALES

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

WHOLE BODY BONE SCAN FOR LUMBAR SPINE: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 309.

Decision rationale: MTUS reference to ACOEM identifies documentation of failure to improve after one month of conservative treatment, as criteria necessary to support the medical necessity of a bone scan. ODG identifies documentation of a diagnosis/condition (with supportive subjective/objective findings) for which a bone scan is indicated (such as: bone infection, cancer, or arthritis), as criteria necessary to support the medical necessity of a bone scan for the lumbar spine. Within the medical information available for review, there is documentation of a diagnosis of chronic low back pain. In addition, there is documentation failure to improve after one month of conservative treatment. However, there is no documentation of a diagnosis/condition (with supportive subjective/objective findings) for which a bone scan is indicated (bone infection, cancer, or arthritis). Therefore, based on guidelines and a review of the evidence, the request for whole body bone scan for lumbar spine is/is not medically necessary.