Case Number:	CM14-0023837		
Date Assigned:	06/11/2014	**Date of Injury:**	08/13/2004
Decision Date:	12/18/2014	**UR Denial Date:**	01/28/2014
Priority:	Standard	**Application Received:**	02/25/2014

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 patient is a 61-year-old woman who sustained a work-related injury on August 13, 2004. She subsequently developed chronic neck and low back pain. MRI of the lumbar spine dated December 23, 2010 showed mild bilateral facet degenerative changes at L5-S1, with mild disc desiccation as well as endplate changes and a broad-based posterior disc bulge measuring 3-4 mm. No neural foraminal narrowing was seen. There was mild disc desiccation at L4-5 with mild degenerative changes; no spinal stenosis or neural foraminal narrowing was present. EMG of the lower extremities bilaterally, dated March 27, 2008 suggested an active bilateral L5-S1 lumbar radiculopathy. Previous treatments included: medications, TENS unit (January 2008), left carpal tunnel release (April 2010), cervical discectomy and fusion C5-6 (March 2012) followed by physical therapy, left foot surgery (July 2012), left knee surgery (January 2014), and cortisone injections left foot 3 times (most recent injection October 2102). According to the progress note dated December 18, 2013, the patient complained of ongoing neck and lower back pain, radiating down the left side of the leg with associated numbness and tingling in the left S1 distribution. Physical examination revealed focal tenderness at the lumbosacral junction, as well as the superior iliac crest on the left side. There was tenderness noted along the left sciatic notch. Motor strength testing was intact. The patient was diagnosed with status post C5-6 ACDF with adjacent level arthrosis at C4-5 and C6-7, as well as spondylosis of L5-S1 and possibly L4-5. Her provider requested authorization for SPECT CT LUMBAR SPINE.

IMR ISSUES, DECISIONS AND RATIONALES

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

SPECT CT lumbar 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 (ODG), Low Back Chapter

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back - Lumbar & Thoracic (Acute & Chronic), SPECT (single photon emission computed tomography)

Decision rationale: According to ODG guidelines, Cervical SPECT 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. 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. 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 rational for the request of lumbar SPECT CT scan. There is no documentation that a metastatic disease of the lumbar spine versus degenerative disc disease is in the differential diagnosis in this patient. Furthermore, there is no documentation of resistant to pain medication that may require investigating other causes of pain for this patient. Therefore, the request for SPECT CT lumbar spine is not medically necessary.