Case Number:	CM14-0091725		
Date Assigned:	07/25/2014	**Date of Injury:**	12/11/1998
Decision Date:	06/15/2015	**UR Denial Date:**	05/21/2014
Priority:	Standard	**Application Received:**	06/17/2014

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: Texas, New York, California
Certification(s)/Specialty: Preventive Medicine, Occupational Medicine

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 applicant is a represented 50-year-old who has filed a claim for chronic mid and low back pain reportedly associated with an industrial injury of December 11, 1998. In a Utilization Review report dated May 21, 2014, the claims administrator failed to approve a request for a bone density scan. The claims administrator referenced progress notes of May 12, 2014 and May 7, 2014 in its determination. The applicant's attorney subsequently appealed. On August 6, 2014, the attending provider commented that the applicant's attorney had appealed the previously denied bone scan. The applicant was using Ambien, Percocet, Zanaflex, and Norco, it was reported. The applicant had undergone an earlier multilevel T9-L2 open reduction, internal fixation, and spinal fusion surgery in 1998, it was acknowledged. The applicant had received multiple epidural steroid injections, it was reported. The applicant's BMI was 26. It was suggested that the applicant was working full time. The applicant was ambulating normally, it was acknowledged. In a June 4, 2014 progress note, the applicant was described as doing well with current medications. The applicant was working on a full-time basis. The applicant had had urine drug testing in February 2012 which was positive for marijuana, it was acknowledged. The attending provider stated that he was ordering bone scanning on the grounds that the applicant was concerned about bone health surrounding the spinal fusion. The applicant was asked to continue current medications and work on a full-time basis. The requesting provider was a pain management physician, it was suggested. On May 7, 2014, the attending provider again noted that the applicant had ongoing complaints of low back pain, unchanged from the preceding visit. The attending provider stated that the applicant had expressed concern about possible osteoporosis on the fusion site. The applicant was 50 years old, it was reported. Multiple medications were renewed. The applicant was returned to regular duty work. A bone scan was ordered.

IMR ISSUES, DECISIONS AND RATIONALES

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

Spine bone density (Dexa) scan: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 61.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Amended 2014 (Resolution 39) ACR SPR SSR PRACTICE PARAMETER FOR THE PERFORMANCE OF QUANTITATIVE COMPUTED TOMOGRAPHY (QCT) BONE DENSITOMETRYII. INDICATIONS AND CONTRAINDICATIONS BMD measurement is indicated whenever a clinical decision is likely to be directly influenced by the result of the test. QCT may be considered in place of or in addition to DXA in the following circumstances: [20-27]. A. Adults with established or clinically suspected low BMD, including: 1. All women age 65 years and older and men age 70 years and older (asymptomatic screening). 2. Women younger than age 65 years who have additional risk for osteoporosis, based on medical history and other findings. Additional risk factors for osteoporosis include: a. Estrogen deficiency. b. A history of maternal hip fracture that occurred after the age of 50 years. c. Low body mass (less than 127 pounds [57. 6 kg]). d. History of amenorrhea (more than 1 year before age 42 years). 3. Women younger than age 65 years or men younger than age 70 years who have additional risk factors, including: a. Current use of cigarettes. b. Loss of height, thoracic kyphosis. 4. Individuals of any age with osteopenia [28] or fragility fractures on imaging studies, computedtomography (CT) or magnetic resonance imaging (MRI) examinations. 5. Individuals age 50 years and older who develop a wrist, hip, spine, or proximal humerus fracture with minimal or no trauma, but excluding pathologic fractures. 6. Individuals of any age who develop 1 or more insufficiency fractures. 7. Individuals receiving (or expected to receive) glucocorticoid therapy for more than 3 months. 8. Individuals beginning or receiving long-term therapy with medications known to adversely affect BMD (e. g. , anticonvulsant drugs, androgen deprivation therapy, aromatase inhibitor therapy, or chronic heparin). 9. Individuals with an endocrine disorder known to adversely affect BMD (e. g. , hyperparathyroidism, hyperthyroidism, or Cushing's syndrome). 10. Hypogonadal men older than 18 years and men with surgically or chemotherapeutically induced castration [29,30]. 11. Individuals with medical conditions that could alter BMD, such as: a. Chronic renal failure. b. Rheumatoid arthritis and other inflammatory arthritides. c. Eating disorders, including anorexia nervosa and bulimia. d. Organ transplantation. e. Prolonged immobilization. f. Conditions associated with secondary osteoporosis, such as gastrointestinal malabsorption, sprue, malnutrition, osteomalacia, vitamin D deficiency, endometriosis, acromegaly, chronic alcoholism orestablished cirrhosis, and multiple myeloma. g. Individuals who have had gastric bypass for obesity. 12. Individuals being considered for pharmacologic therapy for osteoporosis. 13. Individuals being monitored to assess the effectiveness of osteoporosis drug

therapy [31-33] or to follow- up medical conditions associated with abnormal BMD. 14. Individuals with extremes of obesity or low body.

Decision rationale: No, the proposed bone density scan was not medically necessary, medically appropriate, or indicated here. The MTUS does not address the topic. While the American College of Radiology (ACR) notes that bone densitometry testing is indicated in asymptomatic men age 70 years or older, here, however, the applicant is 50 years of age, it was suggested above. While ACR does support bone densitometry testing in applicants in whom a clinical decision is likely to be influenced as a result of the testing, here, however, the attending provider, a pain management physician, did not state how the proposed bone density scanning would influence or alter the treatment plan. The attending provider, a pain management physician, was unlikely to act on the results of the testing in question. ACR also notes that other individuals who are at heightened risk for development of osteoporosis include individuals with known osteopenia, atraumatic fractures, multiple insufficiency fractures, those individuals receiving chronic steroid therapy, those individuals with low body mass index, etc. Here, however, the presence of such risk factors had not been clearly established or articulated. The applicant's BMI was not clearly reported on the May 7, 2014 office visit in question. There was no mention of the applicant's using corticosteroids on a long-term basis. Therefore, the request was not medically necessary.