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**Notice of Independent Review Decision Notice
of Independent Medical Review Decision
Reviewer's Report**

DATE OF REVIEW: July 20, 2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Outpatient bone scan of the spine and non-invasive vascular studies of arterial bilateral legs.

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION

M.D., Board Certified in Neurology.

REVIEW OUTCOME

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

- Upheld (Agree)
 Overturned (Disagree)
 Partially Overturned (Agree in part/Disagree in part)

The requested outpatient bone scan of the spine and non-invasive vascular studies of arterial bilateral legs are not medically necessary.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

1. Notice of Utilization Review Findings dated 6/2/10 and 6/23/10.
2. Request for a Review by an Independent Review Organization dated 6/23/10.
3. Office notes dated 9/26/05 and 10/25/05.
4. Consultation report from Dr. and follow-up visits dated 11/8/05, 12/6/05, 1/10/06, 2/15/06, 2/16/06, 3/21/06, 11/6/06, 2/26/07, 6/19/07, 7/16/07, 9/18/07, 11/19/07, 12/12/07, 1/14/08, 3/11/08, 4/4/08, 6/9/08, 7/1/08, 8/12/08, 10/13/08, 11/24/08, 1/5/09, 3/25/09, 4/8/09, 6/2/09, 7/2/09, 8/11/09, 9/2/09, 10/23/09, 12/10/09, 1/18/10, 4/20/10, and 5/12/10.
5. Physical therapy progress notes dated 9/20/05, 9/26/05, 10/3/05, 10/5/05, 10/6/05, 10/24/05, and 10/25/05.
6. Consultation report from Dr. dated 5/14/10.
7. Texas Workers' Compensation Work Status Report dated 10/25/05.
8. MRI report dated 12/13/05.
9. MRI report dated 3/27/06.
10. MRI report dated 11/16/06.
11. X-ray report dated 1/22/07.
12. Review of Medical History & Physical Exam dated 4/11/07.
13. Impairment Rating Report dated 4/11/07.
14. MRI report dated 2/2/07.
15. Operative report dated 2/22/07.
16. Email correspondence from dated 4/18/07.
17. Denial Information.

PATIENT CLINICAL HISTORY [SUMMARY]:

A review of the record indicates the patient was injured on the job on xx/xx/xx. On 5/12/10, the patient's provider noted the patient had complaints of pain in the lower back and both legs worse on the right than the left. The provider assessed the patient with facet arthropathy of the lumbar spine as the probable source of his pain. The provider recommended repeat MRI of the lumbar spine, EMG/NCS of the lower extremities, bone scan and vascular studies of the lower extremities. At issue in this case is whether a bone scan of the spine and non-vascular studies of arterial bilateral legs are medically necessary for evaluation of the patient's back and hip pain.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION

The submitted evidence does not establish the medical necessity of non-invasive vascular studies of arterial flow to both legs. The records provided are suggestive of herniated disc disease of the lumbo-sacral spine with nerve root compression. There is no documentation of symptoms or evidence of vascular disease of the lower extremities. Thus, there is no clinical indication present for studies of the vascular supply to the lower extremities. Such testing is not likely to yield clinically useful information in this setting, and is not consistent with American College of Occupational & Environmental Medicine (ACOEM) guidelines or Division of Workers Compensation (DWC) policies. Therefore, the requested non-invasive vascular studies are not medically necessary.

With regard to the requested bone scan, the Official Disability Guidelines (ODG) do not support the use of a bone scan in this setting. Per ODG guidelines, a bone scan is not recommended, "except for bone infection, cancer and arthritis." The submitted documentation does not suggest the presence of a bone infection, cancer or arthritis. A bone scan is not the appropriate next step for a patient with this history and symptomatology. As such, the requested bone scan is not medically necessary for evaluation of the patient's condition.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE
- AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES
- DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES
- EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN
- INTERQUAL CRITERIA
- MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS
- MERCY CENTER CONSENSUS CONFERENCE GUIDELINES
- MILLIMAN CARE GUIDELINES
- ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES
- PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR
- TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS
- TEXAS TACADA GUIDELINES
- TMF SCREENING CRITERIA MANUAL
- PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)