

Notice of Independent Review Decision

DATE OF REVIEW: 7/27/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Whole Body Bone Scan (Nuclear Medicine) CPT code 78306

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

The physician performing this review is Board Certified, American Board of Physical Medicine & Rehabilitation. He is certified in pain management. He is a member of the Texas Medical Board. He has a private practice of Physical Medicine & Rehabilitation, Electrodiagnostic Medicine & Pain Management in Texas. He has published in medical journals. He is a member of his state and national medical societies.

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)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

Upon independent review, I find that the previous adverse determination should be upheld. The ODG guidelines have not been met for this service

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Records Received: 19 page fax 07/07/11 Texas Department of Insurance IRO request, 44 page fax 07/11/11 Provider response to disputed services including

administrative and medical. 37 page fax 07/07/11 Provider response to disputed services including administrative and medical Dates of documents range from 5/16/11 to 07/07/11

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient, described as a relatively healthy female, had a work-related injury with pain developing in the left upper extremity, neck, shoulder, and arm area. She was injured while working in a and had a sprain/strain type of injury. Diagnostic studies noted foraminal stenosis at C5-6, and she was undergoing cervical epidural steroid injections. She was responding well, having undergone an initial ESI. However, subsequently, her second ESI 05/16/11 resulted in a brief period of lack of responsiveness following the injection. She was then transferred for hospitalization at and underwent CT scanning of the head and brain area with indication of potential subarachnoid hemorrhage, which was followed in sequence for determination of improvement.

The patient continued to have headaches, which was part of the reason for her undergoing the epidural steroids and was an original part of her initial referral and examination by Dr. Dr. in his letter of 06/20/11 addressing the request for the bone scan indicated that it was his concern that the bone scan had been denied for the wrong problem. He indicated that he had concern that her initial presentation had complaints of some left clavicular and subclavicular pain and was tender. Because it was difficult to differentiate if this was myofascial pain primarily and costochondritis, in order to determine appropriate therapy, he wanted to obtain a bone scan to attempt to differentiate.

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

The *ODG* criteria do not specifically address the need for whole-body bone scan in order to differentiate musculoskeletal pain versus costochondritis in the upper chest area. It is noted that the objective clinical information and specific x-rays of the clavicle and rib areas along with the possibility of MRI studies are recommended in an attempt to further provide objective diagnostic information in the *ODG* for this area. Lacking any specific suspicious type of medical condition for which bone scanning would be considered, such as some form of bone disease or malignancy, the *ODG* does not recommend this as medically reasonable and necessary.

IRO Case
ODG Clavicle Injuries

Description: A fracture of the collarbone. Symptoms include swelling, pain, tenderness, temporary or permanent impairment and, sometimes, visible deformity.

Other names: Broken collarbone

Includes: collar bone
interligamentous part of clavicle

The following fifth-digit subclassification is for use with category 810:

- 0 unspecified part
Clavicle NOS
- 1 sternal end of clavicle
- 2 shaft of clavicle
- 3 acromial end of clavicle

ICD-10 Code: S42.0

ODG Treatment Procedure Summary (not all recommended): [Acromioplasty](#); [Activity restrictions](#); [Acupuncture](#); [Adson's test \(AT\)](#); [Anterior scalene block](#); [Arthrography](#); [Arthroplasty \(shoulder\)](#); [Arthroscopy](#); [Arthroscopic release of adhesions](#); [Bipolar interferential electrotherapy](#); [Biofeedback](#); [Biopsychosocial rehab](#); [Cardiovascular functional testing](#); [Chiropractic](#); [Cold lasers](#); [Continuous-flow cryotherapy](#); [Continuous passive motion \(CPM\)](#); [Corticosteroid injections](#); [Costoclavicular maneuver \(CCM\)](#); [Cutaneous laser treatment](#); [Deep friction massage](#); [Diagnostic arthroscopy](#); [Diathermy](#); [Distension arthrography](#); [Electrical stimulation](#); [Electrodiagnostic testing for TOS \(thoracic outlet syndrome\)](#); [Elevated arm stress test \(EAST\)](#); [Ergonomic interventions](#); [Exercises](#); [Extracorporeal shock wave therapy \(ESWT\)](#); [Hydroplasty/ hydrodilatation](#); [Imaging](#); [Immobilization](#); [Impingement test](#); [Injections](#); [Interferential therapy](#); [Laser therapy](#); [Low level laser therapy \(LLLT\)](#); [Magnetic resonance imaging \(MRI\)](#); [Manipulation](#); [Manipulation under anesthesia \(MUA\)](#); [Massage](#); [Mechanical traction](#); [Modified duty](#); [Multidisciplinary biopsychosocial rehab](#); [Nerve blocks](#); [Osteochondral autologous transplantation \(OATS\)](#); [Physical therapy](#); [Porcine small intestinal submucosa \(SIS\)](#); [Pulsed electromagnetic field](#); [Radiography](#); [Return to work](#); [Rotator cuff repair](#); [Rotator cuff porcine graft repair](#); [Shock wave therapy](#); [Shoulder repair](#); [Steroid injections](#); [Supraclavicular pressure \(SCP\)](#); [Surgery for AC joint separation](#); [Surgery for adhesive capsulitis](#); [Surgery for impingement syndrome](#); [Surgery for rotator cuff repair](#); [Surgery for ruptured biceps tendon](#); [Surgery for shoulder dislocation](#); [Surgery for Thoracic Outlet Syndrome](#); [Thermal capsulorrhaphy](#); [Thermotherapy](#); [Transcutaneous electrical neurostimulation \(TENS\)](#); [Transdermal nitroglycerin](#); [Ultrasound, diagnostic](#); [Ultrasound, therapeutic](#); [Work](#)

ODG Treatment Contents: [ODG/TWC Index](#)

ODG Treatment UR Advisor: [810](#)

Other Links: Click below for detailed information on this condition:

[Merck Manual](#) | [Merck Home Edition](#) | [NGC](#) | [State Guidelines](#)

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)