MAXIMUS Federal Services

Case Number:	CM13-0039159		
Date Assigned:	12/18/2013	Date of Injury:	07/15/2011
Decision Date:	02/10/2014	UR Denial Date:	10/02/2013
Priority:	Standard	Application Received:	10/03/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Orthopedic Surgery 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 physician 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:

This is a 26-year-old, gentleman who apparently had a date of injury on July 15, 2011. Although no mechanism of injury was provided, one of the clinical notes stated that the claimant injured himself while "running" at work. According to the medical records provided in this case, the patient underwent an arthroscopic surgery of his knee on March 14, 2013 where there was noted to be no meniscal involvement of any tearing, however, a plica was identified and this was apparently excised at the time of surgery. The patient continued to have symptoms and a postoperative MRI was obtained on August 10, 2013 that noted a questionable, tiny meniscal tear, but otherwise normal findings with no evidence of any bone pathology or evidence of an infection. Physical examinations on separate occasions both in September and in August of 2013 showed minimal patellofemoral crepitus, but essentially a normal exam otherwise. In a letter by [redacted] dated November 24, 2013, the request for bone scan was made to "see whether or not any objective evidence of inflammation to the knee was present."

IMR ISSUES, DECISIONS AND RATIONALES

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

Request for left knee technetium bone scan: 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), Treatment Index, 11th Edition (web), 2013, Knee and Leg Chapter, Bone Scans.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Treatment in Worker's Comp 18th edition, 2013 Updates, Chapter Knee, Bone scan

Decision rationale: The request for a left knee bone scan cannot be recommended as medically necessary. Since California MTUS Guidelines are silent on this request, the Official Disability Guidelines were utilized. Based on current Official Disability Guidelines regarding bone scan for knees, bone scans are used after total knee replacement if pain caused by loosening of the implant is suspected. After a negative radiograph of loosening of the knee joint and negative aspiration for infection a bone scan may be warranted. Please note in this case, there is obviously no evidence of total knee arthroplasty being performed. The patient is status post arthroscopic procedure with excision of plica. According current Official Disability Guidelines the use of a bone scan would not be warranted or considered medically reasonable in this case. With a history of a negative MRI and no evidence of bony pathology, a bone scan would not typically be utilized to determine any type of inflammatory condition.