

Case Number:	CM14-0210889		
Date Assigned:	12/23/2014	Date of Injury:	11/08/2010
Decision Date:	02/17/2015	UR Denial Date:	12/08/2014
Priority:	Standard	Application Received:	12/16/2014

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 Family Practice and is licensed to practice in Ohio. 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 injured worker is a 61-year-old female the date of injury of November 8, 2010. She tripped a wagon wheel injuring her necks, hands, wrists, shoulders, and low back. Her left knee pain persisted and on February 21, 2012 she underwent a left knee arthroscopy is a partial medial/lateral meniscus removal, synovectomy, and chondroplasty. She continued to complain of severe left knee pain. She had issues with recurring effusions following surgery and there is reference in the chart to having lab work done to exclude infection. Repeat radiographs of the left knee revealed severe tricompartmental arthritis. The injured worker was referred for a possible total knee replacement. However the evaluating orthopedist felt that the symptoms were too rapidly progressing since the time of her arthroscopy. He ordered a CBC, sedimentation rate, C-reactive protein a three phase bone scan. At issue is a request for the three phase bone scan. This was previously noncertified because the injured worker did not have obvious and outward signs of infection and did not have a history of a total knee arthroplasty previously with reference to ODG guidelines. The physical exam of the left knee reveals a 10 flexion deformity with flexion achievable to 110. There is no significant infusion. Crepitus is appreciated. Of significant interest is that the injured worker developed breast cancer in 2013 and underwent bilateral mastectomies, although more information is not available.

IMR ISSUES, DECISIONS AND RATIONALES

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

One 3-phase bone scan: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): able 13 - 6. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Knee & Leg Chapter

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): TABLE 13-2, ALGORITHM 13-1.

Decision rationale: In this instance, the treating physician was concerned because of the rapidly progressive nature of the left knee arthritis. As no joint effusion was present, an aspiration of the knee would not likely have given meaningful results. The injured worker certainly is at risk for infection given her osteoarthritis, previous cortisone injections to the joint, history of chemotherapy treatment, and cancer status. She is also at risk for tumor metastases because of the breast cancer. A bone scan is indicated to exclude potential infection in younger patients although that age limit is not defined well. Therefore, in the absence of a joint effusion a bone scan is recommended to exclude infection of the knee joint in those with risk factors. A bone scan may also be appropriate to exclude metastatic disease. Consequently, a three phase bone scan of the left knee is medically appropriate and necessary.