

<b>Case Number:</b>	CM15-0160164		
<b>Date Assigned:</b>	08/26/2015	<b>Date of Injury:</b>	10/09/2003
<b>Decision Date:</b>	09/29/2015	<b>UR Denial Date:</b>	07/24/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/17/2015

### 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: 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 injured worker is a 64 year old female, who sustained an industrial injury on 10-9-03. Initial complaints were of a slip, fall injury to the left and right knee, and low back. The injured worker was diagnosed as having internal derangement bilateral knees; L5-S1 discogenic pain; lumbar facet arthropathy; right knee osteoarthritis; painful left total knee arthroplasty; possible aseptic loosening for the left total knee arthroplasty. Treatment to date has included status post partial medial; partial lateral meniscectomy; chondroplasty medial joint line; excision of plica synovialis; excision of hypertrophic fat pad; partial synovectomy (3-25-04); status post left total knee replacement (1-20-11); status post manipulation of the left knee under anesthesia ; status post revision left total knee arthroplasty; physical therapy; medications. Diagnostics studies included X-ray taken in the office on 7-9-15. Currently, the PR-2 notes dated 7-9-15 indicated the injured worker complains of back and right knee and left knee pain. He has pain mostly in the back and in terms of right knee he still has pain in the anterior aspect of the knee and the pain varies in intensity. In terms of left knee pain, he reports the knee occasionally gives out. He is in the office on this date for further care and recommendations. On physical examination of the lumbar spine the provider documents tenderness to palpation over the lumbar facet without spasm or deformity or mass or scars. The injured worker walks with a limp and is able to heel-toe walk without focal motor deficit. Sensation as assessed by pinwheel is within normal limits in both extremities. Straight leg raising is negative for any radiating pain. Lumbar x-rays demonstrate facet arthropathy and mild scoliosis. Right knee images show mild patellofemoral arthrosis, some sclerosis along the medial compartment of the knee. The left knee series show

implant in good overall position. The views of the right knee compared to three years ago show some loosening along the posterior femoral condyle, which was, not present three years ago. The provider is requesting authorization of CT of the left knee without contrast; Orthovisc injection with ultrasound guided needle placement 1xwk x 3wks to the right knee and Whole body scan.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**CT of the left knee without contrast:** Overturned

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Knee and Leg Chapter, Computed Tomography (CT).

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 341-343. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee & Leg Chapter/Computed Tomography (CT) Section.

**Decision rationale:** NTUS guidelines state that special studies are not needed to evaluate most knee complaints until after a period of conservative care and observation. The position of the American College of Radiology (ACR) in its most recent appropriateness criteria list the following clinical parameters as predicting absence of significant fracture and may be used to support the decision not to obtain a radiograph following knee trauma: Patient is able to walk without a limp, patient had a twisting injury and there is no effusion. The clinical parameters for ordering knee radiographs following trauma in this population are joint effusion within 24 hours of direct blow or fall, palpable tenderness over fibular head or patella, inability to walk (four steps) or bear weight immediately or within a week of the trauma, inability to flex knee to 90 degrees. Most knee problems improve quickly once any red-flag issues are ruled out. For patients with significant hemarthrosis and a history of acute trauma, radiography is indicated to evaluate for fracture. Reliance only on imaging studies to evaluate the source of knee symptoms may carry a significant risk of diagnostic confusion (false-positive test results) because of the possibility of identifying a problem that was present before symptoms began, and therefore has no temporal association with the current symptoms. Even so, remember that while experienced examiners usually can diagnose an ACL tear in the non-acute stage based on history and physical examination, these injuries are commonly missed or over diagnosed by inexperienced examiners, making MRIs valuable in such cases. Also note that MRIs are superior to arthrography for both diagnosis and safety reasons. Per the ODG, CT of the knee is recommended as an option for pain after TKA with negative radiograph for loosening. One study recommends using computed tomography (CT) examination in patients with painful knee prostheses and equivocal radiographs, particularly for: (1) Loosening: to show the extent and width of lucent zones that may be less apparent on radiographs; (2) Osteolysis: CT is superior to radiographs for this diagnosis; recommend CT be obtained in patients with painful knee prostheses with normal or equivocal radiographs and increased uptake on all three phases of a bone scan to look for osteolysis; (3) Assessing rotational alignment of the femoral component; (4) Detecting subtle or occult periprosthetic fractures. Three-dimensional CT is not recommended for routine preoperative templating in TKA. In this case, the available documentation provides evidence of right knee joint line pain and medial patella facet joint pain. X-ray of the right knee reveals mild patella femoral arthrosis and some sclerosis

along the medial compartment of the right knee. There is also loosening along the posterior femoral condyle compared to an x-ray three years ago. Left knee x-ray reveals an implant in good overall position. Injured worker is diagnosed with a possible loosening of the left total knee arthroplasty. Further evaluation of the left knee is indicated. The request for CT of the left knee without contrast is medically necessary.

**Whole body scan:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Total Body CT Screening - <http://www.aetna.com>.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation <http://www.fda.gov/Radiation-EmittingProducts/RadiationEmittingProductsandProcedures/MedicalImaging/MedicalX-Rays/ucm115340.htm>.

**Decision rationale:** The MTUS guidelines and ODG do not address the use of full body CT scans, therefore, alternative guidelines were consulted. Per the FDA, taking preventive action, finding unsuspected disease, uncovering problems while they are treatable, these all sound great, almost too good to be true. In fact, at this time the Food and Drug Administration (FDA) knows of no scientific evidence demonstrating that whole-body scanning of individuals without symptoms provides more benefit than harm to people being screened. The FDA is responsible for assuring the safety and effectiveness of such medical devices, and it prohibits manufacturers of CT systems to promote their use for whole-body screening of asymptomatic people. The FDA, however, does not regulate practitioners and they may choose to use a device for any use they deem appropriate. Compared to most other diagnostic X-ray procedures, CT scans result in relatively high radiation exposure. The risks associated with such exposure are greatly outweighed by the benefits of diagnostic and therapeutic CT. However, for whole-body CT screening of asymptomatic people, the benefits are questionable. In this case, the available documentation does not provide a rationale for the total body screen that would warrant its use in light of potential risks. The request for whole body scan is not medically necessary.

**Orthovisc injection with ultrasound guided needle placement 1xwk x 3wks to the right knee:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Knee and Leg Chapter, Hyaluronic Acid Injections.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee Chapter/Hyaluronic Acid Injections Section.

**Decision rationale:** The MTUS Guidelines do not address the use of Orthovisc or other hyaluronic acid injections. The ODG recommends the use of hyaluronic acid injection as a possible option for severe osteoarthritis for patients who have not responded adequately to recommended conservative treatments for at least three months to potentially delay total knee replacement. The use of hyaluronic acid injections is not recommended for other knee conditions, and the evidence that hyaluronic acid injections are beneficial for osteoarthritis is inconsistent. There is no indication from the medical documentation provided that the criteria in the ODG have been established to warrant this treatment. The request for Orthovisc injection with ultrasound guided needle placement 1xwk x 3wks to the right knee is not medically necessary.