

Case Number:	CM15-0184298		
Date Assigned:	09/24/2015	Date of Injury:	01/13/2014
Decision Date:	11/10/2015	UR Denial Date:	08/17/2015
Priority:	Standard	Application Received:	09/18/2015

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: Arizona

Certification(s)/Specialty: Surgery

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 47 year old male who sustained an industrial injury on 1-13-2014. A review of medical records indicates the injured worker is being treated for left breast-chest swelling-mass-lump. Medical records dated 6-25-2015 noted mild left burning to chest wall. Physical examination noted left shoulder range of motion was 170 degrees with flexion and abduction, 90 degrees with extension. There was mild tenderness to palpation. Treatment and evaluation included a mammography which showed 2 masses in the superior half of the left breast, biopsy revealing fat necrosis, and a CT of the chest with contrast dated 6-30-2015 which revealed evidence of old granulomatous disease and no visible chest wall muscle mass. Utilization review form dated 8-17-2015 noncertified a left partial mastectomy.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left partial mastectomy: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Article titled "Performance and Practice Guidelines for Breast-Conserving Surgery/Partial Mastectomy".

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Clinician's Guide to Imaging and Pathologic Findings in Benign Breast Disease. Mayo Clin Proc. 2010 Mar; 85(3): 274-279. Benign Breast Diseases: Classification, Diagnosis, and Management. The Oncologist May, 2006. Vol. 11 no. 5 435-449. Fat necrosis of the breast- A review. The Breast (2006) 15, 313-318.

Decision rationale: Fat necrosis represents 2.75% of all benign breast lesions; its incidence is 0.6%.²⁷ The etiologic factors include trauma, radiotherapy, warfarin anticoagulation, breast infection, and invasive breast procedures. In most cases, fat necrosis is clinically occult; however, it can present on clinical examination as a solitary irregular mass or multiple smooth, round, firm nodules. It may be associated with inflammatory skin changes, nipple retraction, and lymphadenopathy occasionally mimicking carcinoma.²⁷ The mammographic and sonographic findings of fat necrosis are occasionally indistinguishable from those of carcinoma, and therefore biopsy may be necessary. Fat necrosis confers no increased risk of breast cancer. Histologically, however, the diagnosis of fat necrosis presents no problem, as it is characterized by anuclear fat cells often surrounded by histiocytic giant cells and foamy phagocytichistiocytes. Excisional biopsy is required if carcinoma cannot be excluded preoperatively. The diagnostic accuracy between large-core needle biopsy and excision (surgical) biopsy are favorably comparable. Parker et al.²⁶ report false negative rates of 1.2-1.5% with large-core needle biopsy. However, core biopsy is often inadequate or indeterminate in the investigation of suspected fat necrosis in the breast. Pullyblank et al.⁴ reported two (4.7%) cases in their series of 42 patients who were found to have malignancy on excision biopsy after a core biopsy diagnosis of fat necrosis. Hence surgical excision biopsy is indicated where there is still suspicion of malignancy following negative core biopsy. In this case, there has been a core biopsy, which revealed fat necrosis, which is consistent with the patient's history of trauma. I do not find a clear reason why excision/lumpectomy has been recommended (pain, core biopsy results discordant with imaging appearance, etc.). Therefore, surgical excision or lumpectomy is not medically necessary and the prior utilization review is upheld.