

Case Number:	CM14-0177963		
Date Assigned:	11/03/2014	Date of Injury:	06/19/1995
Decision Date:	04/24/2015	UR Denial Date:	09/26/2014
Priority:	Standard	Application Received:	10/27/2014

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. 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: Illinois, California, Texas
 Certification(s)/Specialty: Orthopedic 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 57-year-old male who sustained an industrial injury on 6/19/95. Past surgical history was positive for bilateral total knee arthroplasties with right total knee revision arthroplasty on 2/5/13 and left knee total knee arthroplasty revision on 9/16/13. The 7/23/14 right knee x-rays documented he was status post total knee arthroplasty with patellar reconstruction stabilized by a cerclage cable. Hardware appeared intact. There was 1 cm of bony lucency at the tibial tuberosity adjacent to the cerclage cable, which might suggest loosening or bony defect due to prior intervention. Surgical clips were noted posterior to the knee, as well as heterotopic ossification. There was no acute fracture or dislocation. There was mild bony remodeling at the right mid-femur, most likely due to prior intervention. The 8/8/14 treating physician report cited right knee and anterior shin pain. Right knee exam documented antalgic gait, mild effusion, right patellar tendon and shin tenderness, range of motion 5 to 90 degrees, 2/5 knee strength, positive inhibition test, and patella alta. The diagnosis was right knee arthrofibrosis with osteomyelitis. The treatment plan recommended right patellar tendon reconstruction with possible iliotibial band tendon graft and stem cell injection in lieu of allograft extensor mechanism reconstruction. The patient was capable of modified duty. The 9/26/14 utilization review non-certified the request for right patellar tendon reconstruction with possible iliotibial band tendon graft and stem cell injection, with associated surgical requests for 12 post-op physical therapy visits and one month rental of a cold therapy unit. The rationale for non-certification of the surgical request cited no recent diagnostic imaging of a frank patellar tendon full tear to establish medical necessity. The 10/24/14 treating physician report cited worsening of his extensor mechanism

weakness with falls on a daily basis. He was wearing a hinged knee brace but there were no drop locks, so he still had falls. Right knee exam documented active range of motion 50-105 degrees with passive range of motion 5-110 degrees. There was tenderness at the patellar tendon and tibial tubercle. There was mild joint effusion with diffuse anterior knee soft tissue swelling and tenderness. Extension strength was reported 2/5. Patella tracking was within normal limits but the patella rested in an alta position. The diagnosis was right total knee arthroplasty revision with patella alta and patella tendinitis with failure of the patella tendon repair causing severe extension lag.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right patella tendon reconstruction with possible ITB (Iliotibial Band Tendon) tendon graft and stem cell injection: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Treatment in Workers Compensation (TWC), Knee and Leg Procedure summary last updated 08/25/2014.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): s 343-345. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee and Leg: Patellar Tendon Repair; Stem Cell.

Decision rationale: The California MTUS guidelines state that surgical consideration may be indicated for patients who have activity limitations for more than one month and failure of exercise programs to increase range of motion and strength of the musculature around the knee. The Official Disability Guidelines generally recommend patellar tendon repair for full tears. Non-surgical treatment is recommended for partial tears, including physical therapy. Stem cell injections are reported under study for advanced degenerative arthritis, post-menisectomy and microfracture chondroplasty. Guidelines indicate that these treatments remain experimental, and state that techniques are inconsistent and should be limited to randomized controlled clinical trials. Guideline criteria have not been met. There is no imaging evidence in the file to support the medical necessity of surgical intervention relative to a patellar tendon full tear. Detailed evidence of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has not been submitted. There is no evidence of attempted physical therapy or exercise to address the extensor mechanism weakness. Stem cell injections are considered under study and not supported by guidelines. Therefore, this request is not medically necessary.

Postoperative physical therapy for the right knee, 3 times a week for 4 weeks, QTY: 12 sessions: Upheld

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines Page(s): s 24-25.

Decision rationale: As the surgical request is not supported, this request is not medically necessary.

Postoperative rental of a cold therapy unit for the right knee, QTY: 1 month: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 339. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Treatment in Workers Compensation (TWC), Knee and Leg Procedure summary last updated 08/25/2014, Continuous Flow Cryotherapy.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee and Leg: Continuous flow cryotherapy.

Decision rationale: As the surgical request is not supported, this request is not medically necessary.