

<b>Case Number:</b>	CM14-0195518		
<b>Date Assigned:</b>	12/03/2014	<b>Date of Injury:</b>	01/17/2013
<b>Decision Date:</b>	01/21/2015	<b>UR Denial Date:</b>	10/21/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/21/2014

### 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 General Surgeon, has a subspecialty in Surgery of the Hand 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 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:

This case involves a 58-year-old male with a 1/17/2013 date of injury. A specific mechanism of injury was not prescribed. The 10/21/14 determination was non-certified given no literature on TMJ coronoidectomy due to shortening of the temporal tendon. The 11/4/14 letter appears to be incomplete; however, it stated that the patient has post-traumatic fibrous ankylosis and the treatment most commonly used for this disease is a custom total joint reconstruction. In order to perform this procedure, the provider needs to do bilateral coronoidectomies because the temporalis tendon has foreshortened over the many months that the patient has been unable to open his jaw. In order to correct this problems, the provider needs to separate the coronoid tendon from the mandible to allow the mandible to open normally after the fibrous ankyloses has been re-moved. Fat grafting around the joint replacement acts as a blockage to prevent re-fibrous ankylosis from occurring around the joint replacement. Records indicate that an additional determination certified a CT scan of jaw. The following treatments were non-certified: bilateral TMJ replacement, bilateral condylectomy, bilateral coronoidectomy, fat graft, and 26 extractions. In addition, there is documentation that the patient had a healed mandibular fracture with fixation plates and multiple fixation plates as well as screws in the right maxilla and orbital floor. The patient was diagnosed with post-traumatic ankylosis of the bilateral temporomandibular joints.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**One left TMJ coronoidectomy:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation J Craniofac Surg. 2011 May; 22(3):988-91. doi: 10.1097/SCS.0b013e3182101674. Mandibular movement restoration through bilateral coronoidectomy by intraoral approach. Ramalho-Ferreira G1, Faverani LP, Fabris AL, Pastori CM, Magro-Filho O, Ponzoni D, Aranega AM, Garcia-JÃnior IR.

**Decision rationale:** The patient had prior maxillary fractures and developed post-traumatic fibrous ankylosis. The provider proposed a custom total joint reconstruction. In order to perform this procedure, the provider needs to do bilateral coronoidectomies because the temporalis tendon has foreshortened over the many months that the patient has been unable to open his jaw. Literature indicates that coronoidectomy is an effective adjunct in increasing intraoperative and stabilizing postoperative mouth opening. However, there is no indication that the total jaw replacement has been found to be medically necessary. Therefore, this request is not medically necessary.

**One right TMJ coronoidectomy:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation J Craniofac Surg. 2011 May; 22(3):988-91. doi: 10.1097/SCS.0b013e3182101674. Mandibular movement restoration through bilateral coronoidectomy by intraoral approach. Ramalho-Ferreira G1, Faverani LP, Fabris AL, Pastori CM, Magro-Filho O, Ponzoni D, Aranega AM, Garcia-JÃnior IR.

**Decision rationale:** The patient had prior maxillary fractures and developed post-traumatic fibrous ankylosis. The provider proposed a custom total joint reconstruction. In order to perform this procedure, the provider needs to do bilateral coronoidectomies because the temporalis tendon has foreshortened over the many months that the patient has been unable to open his jaw. Literature indicates that coronoidectomy is an effective adjunct in increasing intraoperative and stabilizing postoperative mouth opening. However, there is no indication that the total jaw replacement has been found to be medically necessary. Therefore, this request is not medically necessary.

**One fat graft:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Proc (Bayl Univ Med Cent). Jul 2008; 21(3): 248-254.

PMCID: PMC2446413 Autologous fat grafts placed around temporomandibular joint total joint prostheses to prevent heterotopic bone formation. Larry M. Wolford, DMD, Carlos A. Morales-Ryan, DDS, MSD, Patricia Garcia Morales, DDS, MS, and Daniel Serra Cassano, DDS.

**Decision rationale:** The patient had prior maxillary fractures and developed post-traumatic fibrous ankylosis. The provider proposed a custom total joint reconstruction. In order to perform this procedure, the provider needs to do bilateral coronoidectomies because the temporalis tendon has foreshortened over the many months that the patient has been unable to open his jaw. Literature indicates that coronoidectomy is an effective adjunct in increasing intraoperative and stabilizing postoperative mouth opening. However, there is no indication that the total joint replacement has been found to be medically necessary. Therefore, this request is not medically necessary.