

Case Number:	CM14-0200957		
Date Assigned:	12/11/2014	Date of Injury:	09/18/2008
Decision Date:	02/03/2015	UR Denial Date:	11/14/2014
Priority:	Standard	Application Received:	12/01/2014

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 Neurology, has a subspecialty in Neuromuscular Medicine, and is licensed to practice in New Jersey. 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 patient is a 52-year-old man who sustained a work-related injury on September 18, 2008. Subsequently, he developed left knee pain. MRI of the left knee without contrast dated June 6, 2014 indicated that the patient was status post partial medial meniscectomy and there was a complex multidirectional tear located at the inner posterior horn involving the free edge, superior surface, and inferior surface. There was noted medial compartment osteoarthritis, free edge fraying at the confluence of the body and posterior horn of the lateral meniscus, grade 1 tendinosis involving the 1 cm sagittal length of the proximal patellar tendon, small knee joint effusion with a superior patellar plica and also in the suprapatellar recess, and Hoffa's fat pad fibrosis. According to the follow-up report dated October 27, 2014, the patient complained of left knee pain. The patient was having more pain in the left knee and was working on sedentary type of work. On examination, there was full motion. There was some crepitus around the patella and an inch of atrophy. There was no instability. The provider requested authorization for PRP Injection for the left knee.

IMR ISSUES, DECISIONS AND RATIONALES

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

Platelet Rich Plasma injection for the left knee x 2: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)- TWC Knee and Leg Procedure Summary

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Platelet-rich plasma (PRP), <http://www.worklossdatainstitute.verioiponly.com/odgtwc/elbow.htm#Plateletrichplasma>.

Decision rationale: According to the Official Disability Guidelines, Platelet-rich plasma (PRP) is < Recommend single injection as a second-line therapy for chronic lateral epicondylitis after first-line physical therapy such as eccentric loading, stretching and strengthening exercises, based on recent research below. This small pilot study found that 15 patients with chronic elbow tendinosis treated with buffered platelet-rich plasma (PRP) showed an 81% improvement in their visual analog pain scores after six months, and concluded that PRP should be considered before surgical intervention. Further evaluation of this novel treatment is warranted. This review concluded that there is strong pilot-level evidence supporting the use of prolotherapy, polidocanol, autologous whole blood and platelet-rich plasma injections in the treatment of lateral epicondylitis (LE). Rigorous studies of sufficient sample size, assessing these injection therapies using validated clinical, radiological and biomechanical measures, and tissue injury/healing-responsive biomarkers, are needed to determine long-term effectiveness and safety, and whether these techniques can play a definitive role in the management of LE and other tendinopathy. Using a Gravitational platelet separation system, whole blood can yield platelet-rich plasma. Specially prepared platelets taken from the patient are then re-injected into the tendon of the affected elbow. Platelet-rich plasma contains powerful growth factors that initiate healing in the tendon, but may also send signals to other cells in the body drawing them to the injured area to help in repair. Treatment with PRP is still considered investigational and further research is needed before it can be made available to the general population. According to the author, "The body has an extraordinary ability to heal itself. All we did was speed the process by taking blood from a different area, concentrating it, and putting it back into an area where there was relatively poor blood supply to help repair the damage." Early studies have shown PRP therapy may be useful in maxillofacial surgery, wound healing, microfracture repair, and in the treatment of plantar faciitis. PRP looks promising, but it is not yet ready for prime time. PRP has become popular among professional athletes because it promises to enhance performance, but there is no science behind it yet. PRP was better than corticosteroid injections in relieving pain and improving function in patients with chronic severe lateral epicondylitis, but the study concluded that PRP should be reserved for the most severe cases since 80% of tennis elbows will be cured spontaneously without doing anything within a year>. There is no clear and recent documentation of failure of first line therapies for managing left knee pain. There are no controlled studies supporting the benefit and safety of PRP for severe arthritis. Therefore, the request for platelet rich plasma injection for the left knee is not medically necessary.