

<b>Case Number:</b>	CM15-0011226		
<b>Date Assigned:</b>	01/28/2015	<b>Date of Injury:</b>	04/26/1965
<b>Decision Date:</b>	03/26/2015	<b>UR Denial Date:</b>	12/26/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/20/2015

### 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: New York, West Virginia, Pennsylvania  
 Certification(s)/Specialty: Emergency 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 70 year old male, who sustained an industrial injury on 04/26/1965. He has reported bilateral knee pain. The diagnoses have included degenerative joint disease of the knee; knee joint pain; and medial meniscus derangement. Treatment to date has included medications and hyaluronic acid injections. A progress note from the treating physician, dated 11/21/2014, documented a follow-up visit with the injured worker. The injured worker reported chronic bilateral knee pain, right greater than left; pain is rated 8/10 on the visual analog scale at its worst; pain is sharp, burning shooting, and throbbing; constant limp; and swelling. Objective findings included antalgic gait, slow and guarded; tenderness to palpation of the right and left knees, patellar facet, right greater than left; and positive theater sign. The treating physician recommended bilateral knees stem cell procedure. The treatment plan has included request for 3-Step stem cell transplant procedure to bilateral knees; 1 infrared heating pad; 1 Post-procedure pair of crutches; 1 Post-procedure wheelchair; and 1 prescription, Regenxx supplement; and follow-up evaluation. On 12/26/2014 Utilization Review noncertified a prescription for 1 3-Step stem cell transplant procedure to bilateral knees; 1 infrared heating pad; 1 Post-procedure pair of crutches; 1 Post-procedure wheelchair; and 1 prescription, Regenxx supplement. The CA MTUS, ACOEM, and ODG were cited. On 01/10/2015, the injured worker submitted an application for IMR for review of a prescription for 1 3-Step stem cell transplant procedure to bilateral knees; 1 infrared heating pad; 1 Post-procedure pair of crutches; 1 Post-procedure wheelchair; and 1 prescription, Regenxx supplement.

## IMR ISSUES, DECISIONS AND RATIONALES

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

### **1 3-step stem cell transplant procedure to bilateral knees: 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) Knee & leg (acute & Chronic)

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Stem cells cloning 2014;7;1-17

**Decision rationale:** Evidence based guidelines state that this procedure is under study for treatment of advanced degenerative arthritis, post-meniscectomy but research is preliminary and the procedure is considered experimental. Submitted reports have not demonstrated medical necessity for this procedure such as significant limitations in ADLs, acute flare up or failed treatment trial for this patient. The procedure is not medically necessary and appropriate.

### **1 Infrared heating pad: 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) low Back, Lumbar & Thoracic (acute & Chronic)

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Knee, Infrared therapy

**Decision rationale:** There is no evidence in the medical literature that infrared heating pad is more effective than other heat therapies. Furthermore, there is no discussion concerning the need for variance from the guidelines. The request for post-operative infrared therapy for the knee is not medically necessary and appropriate as the stem cell procedure is also not medically necessary.

### **1 Post-procedure pair of crutches: 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) Knee & Leg (Acute & Chronic)

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

**Decision rationale:** Post procedure crutches would only be necessary and appropriate if a procedure was performed. In this case, the procedure is not medically necessary or appropriate and thus, crutches are not necessary or appropriate.

**1 Post-procedure wheelchair: 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) Knee & Leg (Acute & Chronic)

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

**Decision rationale:** Post procedure wheelchair would only be necessary and appropriate if a procedure was performed. In this case, the procedure is not medically necessary or appropriate and thus, a wheelchair is not necessary or appropriate.

**1 prescription, Regenxx supplement: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Glucosamine Page(s): 50.

**Decision rationale:** Glucosamine is recommended as an option in patients with moderate arthritis pain, especially involving the knee. However, other elements of Regenxx including curcumin, L-carnosine, Resveratrol, and others are not recommended for treatment of chronic pain due to arthritis and meniscal damage of the knee as in this case. Thus, Regenxx is not medically necessary or appropriate in this case.