

Case Number:	CM13-0032683		
Date Assigned:	12/20/2013	Date of Injury:	10/15/2010
Decision Date:	10/24/2014	UR Denial Date:	09/19/2013
Priority:	Standard	Application Received:	10/08/2013

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 Physical Medicine and Rehabilitation 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:

The injured worker is a 52-year-old female who reported an injury 10/15/2010. While at work she was cleaning the bathroom sink and when she exited the bathroom to retrieve something she went into the bathroom, she slipped and tripped on the wet floor. The injured worker fell backwards onto her buttocks. She sustained injuries to her back, buttocks, and right hip. The injured worker's treatment history included surgery, MRI studies, medications, TENS unit, physical therapy, and EMG/NCV studies. The injured worker had undergone EMG/NCV studies on 07/17/2012 that revealed normal nerve conduction velocity study. No evidence of peripheral neuropathy was noted at any level in the bilateral lower extremities. Normal electromyogram. No evidence of active lumbar radiculopathy was noted in the bilateral lower extremities. The injured worker was evaluated on 09/25/2013, and documented the injured worker complained of low back and leg pain. The injured worker still complained of numbness. Objective findings: No change; however, the provider noted there was pain and numbness in right lower leg. Diagnoses included L5 radiculopathy. Request for Authorization was not submitted for this review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Deep Vein Thrombosis (DVT) Max And Pneumatic Compression Wraps: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Venous Thrombosis and Compression Garments.

Decision rationale: The requested is not medically necessary. Official Disability Guidelines (ODG) recommends venous thrombosis Recommend identifying subjects who are at a high risk of developing venous thrombosis and providing prophylactic measures such as consideration for anticoagulation therapy. Minor injuries in the leg are associated with greater risk of venous thrombosis. The relative risk for venous thrombosis is 3-fold greater following minor injury, especially if injury occurs in the 4 weeks prior to thrombosis, is located in the leg, and involves multiple injuries or rupture of muscle or ligament. Risk for venous thrombosis is higher in those with leg injury combined with family history of venous thrombosis (A venous thrombosis is a blood clot that forms within a vein. Deep venous thrombosis (DVTs) form in the deep veins of the legs, and if a piece of a blood clot formed in a vein breaks off it can be transported to the right side of the heart, and from there into the lungs, and is called an embolism, and this process called a venothromboembolism (VTE). Risk factors for venous thrombosis include immobility, surgery, and prothrombotic genetic variants. Studies have addressed the risk for thrombosis following major injury, and minor events, including travel, minor surgery, and minor trauma, are linked to a 3-fold increased risk for venous thrombosis. Venothromboembolism (VTE) is an important condition in hospitalized patients accounting for significant morbidity and mortality. Those at high risk should be considered for anticoagulation therapy during the post-hospitalization period. Aspirin may be the most effective choice to prevent pulmonary embolism (PE) and venous thromboembolism (VTE) in patients undergoing orthopaedic surgery, according to a new study examining a potential role for aspirin in these patients. Patients who received aspirin had a lower VTE risk score than the patients who received warfarin. Patients who received aspirin had a much lower use of sequential compression devices than high-risk patients, but even aspirin patients should receive sequential compression as needed. Patients with suspected deep vein thrombosis (DVT) of the lower extremities are usually investigated with ultrasonography either by the proximal veins (2-point ultrasonography) or the entire deep vein system (whole-leg ultrasonography). The latter approach is thought to be better based on its ability to detect isolated calf vein thrombosis; however, it requires skilled operators and is mainly available only during working hours. These two ultrasound-based evaluations, both with their advantages and disadvantages, are about equally effective at guiding the management of patients with suspected lower-extremity deep-vein thrombosis (DVT), conclude the authors of a large RCT reported in JAMA. But the writer of an accompanying editorial gives the edge to one of the techniques (2-point ultrasonography), the one that's been around longer and is simpler and probably more widely available. However, the use of 2-point ultrasonography to diagnose DVT frequently requires repeated testing in 1 week to detect calf DVT, which can extend to the proximal veins. Whole-leg Doppler ultrasonography generally obviates this requirement, making 1-day testing possible. A systematic review looked at 5 types of interventions used to prevent thromboembolism in pelvic and acetabular fracture patients: mechanical compression devices, inferior vena cava filters, low-molecular weight heparins, ultrasound screening, and magnetic resonance venography screening. Furthermore, the guidelines recommends pneumatic compression wraps when there is good evidence for the use of compression is available, but little is known about dosimetry in compression, for how long and at what level compression should be applied. Low levels of compression 10-30 mmHg applied by stockings are effective in the

management of telangiectases after sclerotherapy, varicose veins in pregnancy, the prevention of edema and deep vein thrombosis (DVT). High levels of compression produced by bandaging and strong compression stockings (30-40 mmHg) are effective at healing leg ulcers and preventing progression of post-thrombotic syndrome as well as in the management of lymphedema. The provider failed to indicate the rationale for why he is requesting deep vein thrombosis. As such, the request for deep vein thrombosis (DVT) max and pneumatic compression wraps is not medically necessary.