

Case Number:	CM14-0020122		
Date Assigned:	05/14/2014	Date of Injury:	06/09/2005
Decision Date:	07/10/2014	UR Denial Date:	02/11/2014
Priority:	Standard	Application Received:	02/19/2014

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 Orthopedic Surgery 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 66-year-old male who reported an injury 06/09/2005. The mechanism of injury was not provided within the medical records. The clinical note dated 02/07/2014 indicated diagnoses of bilateral foot drop. The claimant reported neck pain that radiated into the shoulders and through the mid back rated 8/10. The claimant reported low back pain that radiated into the hips and thighs rated 9/10 and down the bilateral legs to the feet rated 7/10. On physical exam of the lumbar spine and lower extremities, there was palpable tenderness of the paravertebral muscles bilaterally and tenderness centrally in the lower lumbar spine. The claimant had decreased sensation over the left L4 dermatome distribution. Reflexes were absent to the left and right knees as well as the ankles. Hip flexion was 3 on the right, 2 to 3 on the left, knee flexion was 4 on the right and left, knee extension was 3 on the right and the left. Ankle dorsiflexion was 2 to 3 on the right and the left, ankle plantar flexion was 0 on the right and the left, and extensor hallucis longus was 3 on the right and the left. Straight leg raise was positive on the left at 40 degrees and positive on the right at 60 degrees. Prior treatments have included diagnostic imaging, surgery, and medication management. Medication regimen included Prilosec and Percocet. The provider submitted a request for intermittent compression device. A request for authorization was not submitted for review to include the date the treatment was requested.

IMR ISSUES, DECISIONS AND RATIONALES

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

INTERMITTENT COMPRESSION DEVICE: 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 Official Disability Guidelines (ODG), Knee and Leg, VTE (Venous thromboembolism).

Decision rationale: The Official Disability Guidelines (ODG) state intermittent compression devices are recommended for injured workers who are at risk 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 ODG guidelines also state 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, Factor V Leiden mutation or Factor II mutation. The documentation submitted did not indicate the injured worker has findings that would support he is at risk for thrombosis. In addition, there is no justification for the request and the request did not clearly define duration for the treatment. The provider's rationale for the request was not indicated. Therefore, the request for intermittent compression device is not medically necessary and appropriate.