

<b>Case Number:</b>	CM14-0028756		
<b>Date Assigned:</b>	07/30/2014	<b>Date of Injury:</b>	08/14/2011
<b>Decision Date:</b>	10/14/2014	<b>UR Denial Date:</b>	02/11/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/06/2014

### 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 Family Medicine 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 is a female who reported an industrial injury to the back on 8/14/2011, over three (3) years ago, attributed to the performance of her usual and customary job tasks when she bent over to pick up an item and felt pain to her lower back and right lower extremity. The patient was noted to have undergone a prior L3-L4 microdiscectomy. The patient received ongoing conservative care was noted to have decreased low back pain but increased right hip and leg pain with positive spasms and positive SLR. The patient received a lumbar spine epidural steroid injection on 8/7/2013, without significant functional improvement. The patient was diagnosed with a lumbar spine flare-up. The treatment recommendation included a microdiscectomy at L3-L4 followed by postoperative physical therapy. The patient was recommended to have DME of Vascutherm for the vein thrombosis system with hot and cold compression for a four week rental; thoracolumbar Sikka orthosis; and a lumbar garment with DVT calf wrap.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Lumbar Garment:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 308-310.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 298-301. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

Knee and leg chapter cold heat packs; continuous flow cryotherpay; Low back chapter cold/head packs

**Decision rationale:** There is no demonstrated medical necessity for the provision of the Vascutherm DVT prevention system; universal therapy wrap purchase for the requested lumbosacral garment for the application of cold. There is no demonstrated medical necessity for compression therapy post operatively for the prevention of DVT. The patient is noted to have had an initial DVT screening; however, there are no documented issues in the medical history of this patient to establish an increased risk for DVT in this patient in relation to the microdiscectomy. There is no rationale provided to support the medical necessity of the pneumatic compression devise over compression stockings or wrap for the microdiscectomy procedure. The Motorized hot/cold therapy unit and Vascutherm DVT prevention system with a wrap is not medically necessary for the treatment of postoperative pain to the and lumbar garment back and alternatives for treatment of the back are readily available. The request for authorization of the Motorized hot/cold Unit with circulating pads and DVT compression is not supported with objective medically based evidence to support medical necessity. There is no provided objective evidence to support the medical necessity of the motorized hot/cold unit as opposed to the more conventional methods for the application of heat or cold. The concurrent application of intermittent compression to prevent DVT is not demonstrated be medically necessary for the performed procedure. The requesting provider failed to provide a rationale supported with objective evidence to support medical necessity. There is no demonstrated medical necessity for the purchase of the lumbar garment E 1399. There was no rationale by the requesting provider to support medical necessity for the requested DME. Given the above the request is not medically necessary.

**DVT Calf Wrap:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 300, 338. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee and leg chapter cold heat packs; continuous flow cryotherpay; Low back chapter cold/head packs

**Decision rationale:** There is no demonstrated medical necessity for the provision of the Vascutherm DVT prevention system; universal calf wrap purchase. There is no demonstrated medical necessity for compression therapy post operatively for the prevention of DVT. The patient is noted to have had an initial DVT screening; however, there are no documented issues in the medical history of this patient to establish an increased risk for DVT in this patient in relation to the microdiscectomy. There is no rationale provided to support the medical necessity of the pneumatic compression devise over compression stockings or wrap for the microdiscectomy procedure. The Motorized hot/cold therapy unit and Vascutherm DVT prevention system with calf wraps is not medically necessary for the treatment of post operative pain to the back and alternatives for treatment of the back are readily available. The request for authorization of the Motorized hot/cold Unit with circulating pads and DVT compression is not

supported with objective medically based evidence to support medical necessity. There is no provided objective evidence to support the medical necessity of the motorized hot/cold unit as opposed to the more conventional methods for the application of heat or cold. The concurrent application of intermittent compression to prevent DVT is not demonstrated be medically necessary for the performed procedure. The requesting provider failed to provide a rationale supported with objective evidence to support medical necessity. There is no demonstrated medical necessity for the purchase of the DVT Wraps. There was no rationale by the requesting provider to support medical necessity for the requested DME. Given the above the request is not medically necessary.

**VacuTherm and DVT system with hot/cold compression 4 week rental:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 308-310.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 300, 338. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee and leg chapter cold heat packs; continuous flow cryotherapy; Low back chapter cold/head packs

**Decision rationale:** There is no demonstrated medical necessity for the provision of the VascuTherm DVT prevention system; universal calf wrap purchase. There is no demonstrated medical necessity for compression therapy post operatively for the prevention of DVT. The patient is noted to have had an initial DVT screening; however, there are no documented issues in the medical history of this patient to establish an increased risk for DVT in this patient in relation to the microdiscectomy. There is no rationale provided to support the medical necessity of the pneumatic compression device over compression stockings or wrap for the microdiscectomy procedure. The Motorized hot/cold therapy unit and VascuTherm DVT prevention system with calf wraps is not medically necessary for the treatment of post operative pain to the back and alternatives for treatment of the back are readily available. The request for authorization of the Motorized hot/cold Unit with circulating pads and DVT compression is not supported with objective medically based evidence to support medical necessity. There is no provided objective evidence to support the medical necessity of the motorized hot/cold unit as opposed to the more conventional methods for the application of heat or cold. The concurrent application of intermittent compression to prevent DVT is not demonstrated be medically necessary for the performed procedure. The requesting provider failed to provide a rationale supported with objective evidence to support medical necessity. There is no demonstrated medical necessity for the requested four (4) week rental of the VascuTherm DVT system with hot/cold compression. There was no rationale supported with objective evidence to support the medical necessity of the requested DME. Given the above the request is not medically necessary.