

Case Number:	CM14-0036858		
Date Assigned:	10/15/2014	Date of Injury:	08/12/1997
Decision Date:	11/18/2014	UR Denial Date:	03/04/2014
Priority:	Standard	Application Received:	03/26/2014

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 53-year old warehouse supervisor reported a neck injury after a table fell and struck him on the head on 8/12/97. He had an anterior cervical discectomy in 1992 and a 3-level cervical fusion with hardware in 1999. Other treatments have included chiropractic manipulation, physical therapy, massage therapy, psychotherapy, acupuncture, biofeedback, magnet therapy and numerous epidural steroid injections. He completed a functional restoration program, but remains off work. His most recent cervical epidural steroid injection was on 2/13/14. There is only one progress note in the records from the primary treater's office, dated 12/5/13 and signed by a PA with the primary treater's countersignature. It states that the patient continues to have neck pain which radiates down the left arm, grip strength weakness and clumsiness of the hands. Current medications include Norco 10, Ambien, Flexeril, Fentanyl patch, Tramadol and Compazine. Physical exam was notable for a BMI of 21, tenderness of the neck and bilateral trapezius region, decreased neck range of motion, positive Spurling's and Hoffman's tests, mild weakness of the left greater than right elbow and decreased sensation in a right C4 dermatomal distribution. Diagnoses included cervical radiculopathy, cervical stenosis, and cervicgia. The plan was to perform an anterior cervical discectomy and arthrodesis with hardware removal and application of intervertebral biomechanical device(s) to be done in late February per patient request. A cardiac clearance was requested. A surgical clearance by a cardiologist had already been performed (on 10/8/13) at the time the request was made. It noted that the patient had a normal EKG and a normal exam, that there were no significant risk factors, and that the patient should be low risk for surgery. The records contain a prescription for a Vascutherm unit for DVT prophylaxis, for a period of 30 days. The prescription form was clearly generated by the Vascutherm supplier, and has check boxes for DVT risk. The boxes that are checked include

only patient age 41-60 years, history of prior major surgery less than 1 month, and major surgery lasting 2-3 hours.

IMR ISSUES, DECISIONS AND RATIONALES

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

Vascutherm 30 day rental: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 181-183. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and Upper back and Shoulder

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 174. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), knee, hip and shoulder sections, venous thrombosis; neck and upper back section, cryotherapy

Decision rationale: According to the manufacturer, a Vascutherm device provides constant regulated cooling and compression for DVT (deep venous thrombosis) prophylaxis. It is not clear where the device would be applied in this case, since the surgery is being performed on the neck. Presumably the device would be used on the neck, on the upper limbs, or on the lower limbs. The ACOEM guidelines cited above recommend cold packs during the first few days for neck pain, and heat thereafter. There is no recommendation for any specific device in order to accomplish this. Cold can be applied to the skin using simple home materials, e.g. ice, without any formal medical device or equipment. Per Page 48 of the Guidelines, heat or cold may be used for two weeks or less. The updated ACOEM chronic pain section state that examples of cryotherapy include towels moistened with cold water, ice wrapped in a blanket, ice massage, cold water and/or ice placed in a "water bottle," gel packs, cooling sprays, or single-use chemical packets that produce cooling on breaking one pouch inside to start a chemical reaction. Routine use of cryotherapies in health care provider offices or the use of high tech devices is not recommended for treatment of any chronic pain condition. The ODG neck section recommends against continuous flow cryotherapy for the neck. Per the ODG guidelines cited above, mechanical compression should be used (unless contraindicated) in the recovery room and during the hospital stay for all patients undergoing arthroplasty of the knee or hip. For high-risk patients, compression devices may be used during surgery, and thromboprophylactic medications are also recommended. Venous foot pump or intermittent pneumatic compression should be used for patients with a high risk of bleeding who undergo total knee or hip replacement. When the risk of bleeding decreases, thromboprophylactic medications should be substituted for the mechanical devices. When outpatient compression is required, compression stockings may be used at home. Regarding shoulder surgery and upper limb venous thrombosis, the ODG guidelines state that deep venous thrombosis has an incidence of 1 case per thousand overall, and is very rare after arthroscopy of the shoulder. DVT prophylaxis is not generally recommended in shoulder arthroscopy procedures. The clinical findings in this case do not support the use of an intermittent limb compression and cryotherapy device for 30 days at home. There is no documentation of a concern for deep venous thrombosis (DVT) in preoperative clearance notes by a cardiologist. The primary provider did not document any concerns prior to surgery. The specific concerns on

the letter of medical necessity that are checked include major surgery within the past month (which is not correct), and the patient's age and length of surgery planned. These factors do not place him at high risk for DVT. It is not clear for which limb this device is intended. If there is concern about lower limb DVT in this case, optimal treatment would consist of compression stockings, prophylactic medications, and early mobilization. The use of a pneumatic compression device in this case might actually increase the patient's risk for DVT, since it cannot be used while the patient is ambulating and would thus require him to spend significant time seated or lying. The evidence-based guidelines cited above would also not support the use of this device for the upper limb, if that is in fact what was intended. DVT prophylaxis is not generally recommended for the upper limb except in unusually high-risk patients, and there is no documentation that this is the case. Cryotherapy to either the upper or lower limbs after a neck surgery would not make medical sense, nor would compression to the neck. According to the evidence-based guidelines cited above and to the clinical findings in this case, an intermittent limb compression/cryotherapy device 30-day rental is not medically necessary.