

Case Number:	CM14-0090055		
Date Assigned:	09/10/2014	Date of Injury:	11/18/2004
Decision Date:	10/10/2014	UR Denial Date:	05/14/2014
Priority:	Standard	Application Received:	06/16/2014

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 Physical Medicine and Rehabilitation, has a subspecialty in Interventional Spine, 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 patient is a 52 year old female with an injury date of 11/18/04. The 03/20/14 report by ■■■■■ states that the patient presents with postoperative incisional pain (March 2014) and lower back pain and left lower extremity pain. Pain is significantly improved with medication. Examination reveals the incision is healing well and sensation is intact to light touch in all major dermatomal groups. The patient's diagnoses from 03/20/14 and 03/07/14 reports include: 1. Lumbar pain now improving on current medical regimen². Delayed wound healing now appears to be closely approximated and healing well with scant to no drainage with time and antibiotic regimen. 3. Status post left transforaminal lumbar interbodyfusion of L2-L3 bilateral pedicle screw rod fixation and posterolateral arthrodesis of L2-L3⁴. Acute pain secondary to #35. Hypertension⁶. Depression⁷. Anxiety⁸. Seasonal asthma⁹. Postoperative acute blood loss anemia¹⁰. Deep Venous thrombosis prophylaxis; continue ambulation Current medications are listed as Oxycodone, Dilaudid, Valium, Neurontin, Kerflex, and Bactrium. The utilization review being challenged is dated 05/14/14 and the rationale is that compliance with VTE protocols continues to be less than 100% and even when patients adhere to protocols VTE events continue to occur. It is also not clear that the patient is at high risk for DVT, and there is limited evidence that the requested unit is superior to oral prophylaxis/ASA therapy and or/compression garments. Reports were provided from 11/21/13 to 08/19/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

Vascutherm (Poly cystic ovarian) PCO for (Deep Vein Thrombosis) DVT for 30 Days:
Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300, Chronic Pain Treatment Guidelines Evidence citations for (Durable Medical Equipment) DME. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) TWC Low Back Procedure Summary last updated 3/31/14

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Hip & Pelvis and Knee & Leg Sections

Decision rationale: The patient presents with pain to the lower back, left lower extremity and post operational incision pain. The patient is s/p lumbar surgery from March 2014. The treater requests for Vacutherm for Deep Vein Thrombosis prophylaxis for 30 days. On line research shows that Vacutherm is a compression and localized thermal therapy device with DVT prophylaxis. MTUS is silent on Deep Vein Thrombosis. An ODG guideline does address post-operative treatments for DVT prophylaxis and states, "Risk factors include immobility, surgery and prothrombotic genetic variants. 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 much lower use of sequential compression devices than high-risk patients, but even aspirin patients should receive sequential compression as needed. (Bozic, 2008) Using data from the prospective Million Women Study in the UK, new research suggests that the risk of venous thromboembolism (VTE) after surgery is greater and lasts for longer than has previously been appreciated. They show that the risk is greatest in the first six weeks following surgery, peaking around three weeks afterward. Current evidence suggests it is needed for inpatients undergoing many orthopedic-, general-, and cancer-surgery procedures and should be given for at least seven to 10 days. In addition, prolonged prophylaxis for four to five weeks also shows a net clinical benefit in high-risk patients and procedures. Although mechanical methods do reduce the risk of deep vein thrombosis [DVT], there is no evidence that they reduce the main threat, the risk of pulmonary embolism [PE], fatal PE, or total mortality. In contrast, pharmacological methods significantly reduce all of these outcomes." In this case, the patient is s/p lumbar surgery with fusion requiring hospital stay. DVT prophylaxis appears reasonable. However, the request is for 30 days of compression which appears excessive. The treater does not explain why the patient requires such a prolonged use of the compression. The patient should have been able to walk around after 3-5 days following surgery. The treater does not discuss use of ASA or oral anticoagulation which should be the main stay treatment for DVT prophylaxis. Therefore, this request is not medically necessary.