

<b>Case Number:</b>	CM13-0029165		
<b>Date Assigned:</b>	03/17/2014	<b>Date of Injury:</b>	04/19/2012
<b>Decision Date:</b>	03/27/2015	<b>UR Denial Date:</b>	09/23/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/24/2013

### 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:  
 State(s) of Licensure: Oregon, California  
 Certification(s)/Specialty: Neurological Surgery

### 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 36-year-old male who reported an injury on 04/19/2012. The injury reportedly occurred to his lower back when he was coming out of a pool at work. He is diagnosed with lumbar sprain/strain, low back pain with radicular symptoms, and lumbar disc protrusion. His past treatments have included physical therapy, chiropractic treatment, home exercise, epidural steroid injections, and medications. At his followup visit on 09/05/2013, the injured worker's symptoms were noted to include low back pain with radiating symptoms into the bilateral lower extremities. His physical examination revealed a positive right straight leg, and decreased sensation in the right lower extremity and L4-S1 distributions. The treatment plan included a right sided lumbar discectomy at L5-S1, as well as postoperative DME, medication, and physical therapy. Requests were submitted for the recommended spinal surgery, urinalysis, re-evaluation within 6 weeks, a 2 day hospital stay, postoperative evaluation, a 3 in 1 commode, back brace, and motorized hot/cold unit. The motorized hot/cold unit was recommended to be used for 30 days to reduce pain, edema, swelling, and relax muscle spasms. A previous determination letter dated 09/23/2013, indicates that the right sided lumbar discectomy at L5-S1 was certified. However, requests for a DVTMAX purchase and pneumatic compression wrap purchase were non-certified, as there was no clear rationale for the purchase of the DVT unit, and the injured worker was not noted to have significant risk factors for DVT.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**ASSOCIATED SURGICAL SERVICE: DVTMAX PURCHASE:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Knee & leg: Venous thrombosis, Compression garments, Continuous-flow cryotherapy.

**Decision rationale:** According to the Official Disability Guidelines, subjects who are a high risk for developing venous thrombosis should be identified and provided prophylactic measures, such as consideration for anticoagulant therapy. It was also noted that studies have indicated the risk for thrombosis is increased following major injury, minor surgery, travel, and minor trauma. However, the Official Disability Guidelines also state that low levels of compression applied by compression stockings have been shown to be effective in the prevention of DVT. Additionally, continuous flow cryotherapy units are recommended after surgery, but only for up to 7 days. The clinical information submitted for review indicated that the injured worker was recommended for surgery and a cold therapy unit. While the surgery was found to be appropriate, the requested DVTMAX and pneumatic compression wraps were found to be not medically necessary. The submitted clinical information failed to show documentation that the injured worker has an increased risk for DVT following his approved surgery, and cold therapy units are only recommended for use up to 7 days. For these reasons, the request is not medically necessary.

**ASSOCIATED SURGICAL SERVICE: PNEUMATIC COMPRESSION WRAPS PURCHASE:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.