MAXIMUS Federal Services

Case Number:	CM14-0188231		
Date Assigned:	11/18/2014	Date of Injury:	08/06/2002
Decision Date:	01/07/2015	UR Denial Date:	10/14/2014
Priority:	Standard	Application Received:	11/12/2014

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 Califoria. 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 45-year old man has diagnoses of cervical radiculopathy and herniated nucleus pulposis at L5-S1. The available records contain various dates of injury including 8/6/02, 8/6/04, 8/10/04 and 8/10/14. No mechanism of injury is described. There is an operative report dated 9/24/14 for "C5-6 lumbar" local anesthetic and epidural steroid injection, which appears to have involved cervical steroid injections only. There are no complications of the procedure recorded. There is only one clinical progress report in the records, dated 9/25/14. The patient is reported as having slight pain relief from the previous day's cervical ESI's. His low back pain is worse. Exam is notable only for tenderness and decreased range of motion of the neck and low back. Treatment plan included a Toradol injection. Voltaren, Ultram and Prilosec were prescribed. No mention is made of any concern for deep venous thrombosis, or of any need for a compressive device. The records contain an authorization request for a DVT intermittent pneumatic compression device to be worn 9/24/14, as well as another request for authorization of a DVT calf cuff and pump which is presumably for the same device. No specific reason is documented for either request. The patient's work status is not documented, but he can be presumed to be ambulatory since he was seen for an outpatient visit on 9/25/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

DVT Intermittent Pneumatic Compression Device, Rental with Date of service 9-24-14:
Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation ODG (Official Disability Guidelines) American Academy of Orthopedic Surgeons clinical guidelines

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), knee, hip and shoulder sections, (Note that the ODG neck section does not address prophylaxis for deep venous thrombosis (DVT). Other Medical Treatment Guideline or Medical Evidence: Up to Date, an online evidence-based review service for clinicians (www.uptodate.com), Prevention of thromboembolic disease in surgical patients.

Decision rationale: 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 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. According to the Up to Date reference, risk factors for post-operative DVT include increasing age (particularly over 60), prior history of DVT in patient or family member, presence of malignancy or obesity, presence of hypercoagulable state, and one or more significant medical comorbidities including heart disease, infection, inflammatory conditions, recent stroke or pre-operative sepsis. Risk also increases according to the surgery performed, with high risk procedures including any surgery with operative time of two hours or more. Gynecological, urological, thoracic, ankle fracture, and neurosurgical procedures usually fall into the moderate risk category. High risk surgeries include hip or knee arthroplasty, pelvic or hip fracture surgery, colorectal surgery, major trauma surgery, spinal cord injury surgery, and cancer surgery. The clinical documentation in this case does not support the use of a DVT intermittent pneumatic compression device. There are no documented risk factors for DVT, or of any concern at all for DVT occurrence. The procedure involved (cervical ESI's), if in fact it could be deemed a surgery, is very low risk, and does not involve any significant period of immobility. Since the procedure is performed on an outpatient basis and can be presumed to have been quite short, though its length of time is not documented. The patient was clearly ambulatory by the following day. If in fact there were 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. According to the evidence-based citations above and the clinical documentation provided for my review, a DVT intermittent pneumatic compression device is not medically necessary. It is not medically necessary because it was requested for a patient with no documented risk factors for DVT who underwent a very minor low risk procedure, which would

mean that in this case such a device would not be likely to be helpful and might actually interfere with ambulation and place the patient at higher risk for DVT.