

Case Number:	CM15-0137040		
Date Assigned:	07/27/2015	Date of Injury:	12/11/2001
Decision Date:	08/25/2015	UR Denial Date:	07/10/2015
Priority:	Standard	Application Received:	07/15/2015

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: California, Oregon, Washington
Certification(s)/Specialty: Orthopedic 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 54 year old female who sustained an industrial/work injury on 12/11/01. She reported an initial complaint of bilateral hand, wrist, finger, thumb, right forearm, and right elbow pain. The injured worker was diagnosed as having left volar wrist ganglion, neuropathy of upper extremity, pain in joint, myofascial/fibromyofascial, muscle spasm, chronic pain syndrome, depression, and anxiety. Treatment to date includes medication, surgery (excision of left volar wrist ganglion on 9/9/14), physical therapy, and injections. Currently, the injured worker complained of pain in bilateral wrists rated 4/10. Per the primary physician's report (PR-2) on 6/15/15/15, exam noted normal muscle strength 5/5 and orthopedic tests were negative. The requested treatments include post-operative Home Pneumatic Intermittent Compression Device with Bilateral Calf Wraps (retrospective DOS 9/9/14).

IMR ISSUES, DECISIONS AND RATIONALES

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

Post operative Home Pneumatic Intermittent Compression Device with Bilateral Calf Wraps (retrospective DOS 9/9/14): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines: Knee & Leg (Acute & Chronic) - Venous thrombosis.

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

Decision rationale: CA MTUS/ACOEM is silent on the issue of DVT compression garments. The ODG, Knee and Leg section, Compression Garments, summarizes the recommendations of the American College of Chest Physicians and American Academy of Orthopedic Surgeons. It is recommend to use of mechanical compression devices after all major knee surgeries including total hip and total knee replacements. In this patient there is no documentation of a history of increased risk of DVT or major knee surgery. The patient underwent a routine ganglion cyst removal. Therefore medical necessity cannot be established and therefore the determinations for non-certification for the requested device, therefore not medically necessary.