

Case Number:	CM15-0169378		
Date Assigned:	09/10/2015	Date of Injury:	03/09/2001
Decision Date:	10/13/2015	UR Denial Date:	08/19/2015
Priority:	Standard	Application Received:	08/27/2015

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: Illinois, California, Texas

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:

This injured worker is a 74-year-old woman who sustained an industrial injury on 3/09/01. Injury occurred relative to repetitive loading and unloading boxes during an office move. Past medical history was positive for depression, osteoporosis, and gastritis. Social history noted that she smoked a few cigarettes a day. Past surgical history was positive for L2 through S1 posterior lumbar interbody fusion on 12/6/07 with removal of 2 pedicle screws in June 2008 and posterior fusion hardware on 9/21/09, spinal cord stimulator implant on 10/17/11 with revision in November 2013, and lateral T11-L1 fusion in early 2014. The 4/15/15 thoracic CT scan impression documented post-operative changes status post fusion of the T11-L1 vertebral bodies with no complication or central canal compromise. There were age-indeterminate compression fractures of T7 and T11 with no central canal compromise. There was no significant disc bulge or protrusion seen, and normal caliber central canal and foramina throughout the thoracic spine. The 4/15/15 thoracic spine x-ray impression documented fracture of the T12 vertebral body with patient status post fusion of the T11-L1 vertebral bodies. Screws and a rod were in place. There was kyphotic angulation with the apex at the T12 level due to the fracture, and a compression fracture of T7 with mild to moderate anterior height loss. The 5/7/15 treating physician report cited severe thoracolumbar pain with muscle spasms and inability to stand straight. Physical exam documented 4/5 bilateral hip flexor weakness, sensory loss over the anterior thighs bilaterally, and symmetric deep tendon reflexes. Gait was not stable. She leaned forward when walking and used a front-wheeled walker for ambulation. Imaging showed a compression fracture of the T11 body causing over 30% kyphosis at the T10/11 disc level. The treatment plan recommended an interbody fusion at T10/11 to correct the severe kyphosis using the left lateral approach and a minimal invasive technique with instrumentation. The 5/21/15 durable medical

equipment prescription form requested deep vein thrombosis (DVT) prophylaxis unit for 30 days, bone growth stimulator, electrical stimulation unit, and thoracolumbosacral orthosis. The DVT risk assessment indicated that the injured worker was at high risk based on major surgery lasting 2-3 hours, advanced age, general anesthesia greater than 30 minutes, and high risk of bleeding. She underwent interbody and lateral fusion at T10-T11 using a transthoracic left lateral approach on 6/03/15. The 7/2/15 treating physician report indicated that the injured worker fell on her chest while in the acute inpatient rehabilitation unit following surgery. A rib series was requested to rule-out fractures and extension of the DVT prophylaxis unit rental for 30 days was recommended. Authorization was requested for DVT (deep vein thrombosis) prophylaxis, 30-day rental. The 8/19/15 utilization review non-certified the request for DVT prophylaxis, 30-day rental as there was no pertinent medical history provided to indicate the medical necessity of a compression device. The undated appeal letter submitted by the treating physician indicated that a DVT prophylaxis unit was recommended to aid with post-operative healing and reduce the risk of DVT and pulmonary embolism. The unit would help with functional limitations in activities of daily living and assist in pain relief. She underwent a T10/11 fusion under general anesthesia that lasted more than 3 hours and was 74 years old, which placed her at high risk for developing DVT. Following surgery, ambulation might be an issue and increase the risk for DVT.

IMR ISSUES, DECISIONS AND RATIONALES

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

DVT (Deep Vein Thrombosis) prophylaxis, 30 day rental: Upheld

Claims Administrator guideline: Decision based on MTUS Low Back Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Knee & Leg (updated 07/10/2015) - Online Version Deep vein thrombosis (DVT).

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: Venous Thrombosis.

Decision rationale: The California MTUS guidelines are silent with regard to deep vein thrombosis (DVT) prophylaxis. The Official Disability Guidelines (ODG) recommend identifying subjects who are at a high risk of developing venous thrombosis and providing prophylactic measures, such as consideration for anticoagulation therapy. Risk factors included advanced age, length of surgery, and duration of anesthesia. The injured worker was reported at high-risk for bleeding but this was not specified. There is no specific documentation that anticoagulation therapy would be contraindicated, or standard compression stockings insufficient, to warrant the use of mechanical prophylaxis over a protracted length of time. There is no compelling rationale to support the medical necessity of this request for an extended period of time as an exception to guidelines. Therefore, this request is not medically necessary.