

Case Number:	CM15-0185426		
Date Assigned:	10/02/2015	Date of Injury:	05/13/2010
Decision Date:	11/10/2015	UR Denial Date:	08/12/2015
Priority:	Standard	Application Received:	09/21/2015

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 50-year-old female who sustained an industrial injury on 5/13/10, relative to a trip and fall. Past medical history was positive for anxiety and a heart murmur as a child. The 4/30/15 cervical spine MRI impression documented a 0.5 to 1 mm C3/4 disc bulge somewhat eccentric to the right, and a 1 mm central disc protrusion at C6/7. At C5/6, there was at least mild disc space narrowing with a 1.5 mm broad-based disc bulge with mild central canal stenosis without extrinsic cord compression, and very mild bilateral nerve root canal stenosis. There was a small syrinx at the C6/7 level with no associated cord parenchymal abnormalities and no evidence for a Chiari 1 malformation. The 6/22/15 initial orthopedic consult cited neck and upper extremity weakness with a Neck Disability Index of 72%. She had a 5-year history of persistent neck pain with primary left wrist extensor weakness. Symptoms were aggravated by lifting or overhead activity and by motion. Medications, chiropractic, physical therapy, and acupuncture did not provide sustained relief. Neurologic exam documented normal sensation, 4/5 left wrist extensor weakness, 2+ and symmetrical deep tendon reflexes. She had a normal balanced gait and was able to walk on her toes and heels without difficulty. X-rays showed C5/6 degenerative disc disease and disc height loss with no instability on flexion/extension films. Imaging documented C5/6 degenerative disc disease with posterior disc protrusion resulting in central stenosis and lateral foraminal stenosis. At C6/7, there was a small syrinx. The treatment plan recommended a left C5/6 epidural steroid injection for diagnostic and therapeutic purposes. The 8/3/15 treating physician report indicated that she had 48-hours of complete relief of left upper extremity pain, numbness and tingling after a C5/6 epidural injection,

followed by dramatic return of excruciating pain. Physical exam documented sensory loss on the left at the C6 and C7 dermatomes. Otherwise, exam findings were unchanged from 6/22/15. Authorization was requested for C5/6 cervical discectomy and fusion with purchase of a cervical collar, post-operative physical therapy 2x6, and "SCD cuff half leg out" (HCPCS code E0670). The 8/12/15 utilization review certified the C5/6 cervical discectomy and fusion with cervical collar and 12 visits of post-op physical therapy. The request for purchase of a SCD cuff leg out was non-certified as the request was not understandable.

IMR ISSUES, DECISIONS AND RATIONALES

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

SCD cuff leg out: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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: This request for "SCD cuff half leg out" is reported in the medical records as HCPCS code E0670, which is consistent with a segmental pneumatic compression device. 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. Guideline criteria have not been met. There are limited DVT risk factors identified for this patient. There is no documentation that anticoagulation therapy would be contraindicated, or standard compression stockings insufficient, to warrant the use of mechanical prophylaxis. Therefore, this request is not medically necessary.