

Case Number:	CM15-0199925		
Date Assigned:	10/15/2015	Date of Injury:	12/18/2010
Decision Date:	12/14/2015	UR Denial Date:	09/30/2015
Priority:	Standard	Application Received:	10/12/2015

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: Arizona

Certification(s)/Specialty: 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 52 year old male, who sustained an industrial injury on December 18, 2010. The injured worker was diagnosed as having right femoral fracture with rod in 2010, left hip dislocation with surgery left acetabulum fracture, bilateral knee meniscal tear, facial and hand burns, lung damage with pain, left elbow pain, and eye burning. Treatment and diagnostic studies to date has included medication regimen, status post surgery to the hands for burns, and psychological evaluation. In a progress note dated July 17, 2015 the treating physician reports complaints of pain to the bilateral knees, left hip, and history of burnt hands. Examination performed on July 17, 2015 was revealing for drainage to the right hand, scarring to the bilateral hands secondary to burns, right side facial burns, pain to the right hip, tenderness to the left greater trochanter, pain to the left groin with Faber's testing, pain to the lateral left hip, tenderness to the left knee, tenderness medial and lateral bilateral knees, and pain with range of motion to the bilateral knees. The treating physician requested deep vein thrombosis intermittent pneumatic compression device and deep vein thrombosis compression sleeves with a quantity of 1 pair, but the documentation provided did not indicate the specific reason for the requested equipment. On September 30, 2015 the Utilization Review determined the retrospective requests for deep vein thrombosis intermittent pneumatic compression device and deep vein thrombosis compression sleeves with a quantity of 1 pair for the date of service of August 04, 2015 to be non-certified.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective request for DVT (deep vein thrombosis) intermittent pneumatic compression device, date of service: 08/04/2015: 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), Knee and Leg, (Acute & Chronic): Venous Thrombosis, 2015.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Venous thromboembolism prophylaxis, National Guideline Clearinghouse, From US Dept of Health and Human Services. <https://www.guideline.gov/content.aspx?id=39350>.

Decision rationale: For patients undergoing general, GI, urological, gynecologic, bariatric, vascular, plastic or reconstructive surgery, the 2012 American College of Chest Physicians Clinical Practice guideline recommends the following [Guideline]: For patients at very low risk for VTE (Caprini score, 0), recommend no specific pharmacologic or mechanical thromboprophylaxis be used other than early ambulation. For patients at moderate risk for VTE (Caprini score, 3-4) who are at high risk for major bleeding complications are thought to be particularly severe, suggest mechanical thromboprophylaxis, preferably with IPC, over no prophylaxis. For patients at high risk for VTE (Caprini score, >5) who are not at high risk for major bleeding and for whom complications are thought to be particularly severe, recommend pharmacologic thromboprophylaxis with LMWH or LDUH over no prophylaxis. It is suggested that mechanical thromboprophylaxis with IPC should be added to pharmacologic thromboprophylaxis. For high-VTE-risk patients who are at high risk for major bleeding complications or those in whom the consequences of bleeding are thought to be particularly severe, suggest the use of mechanical thromboprophylaxis, preferably with IPC, over no prophylaxis until the risk of bleeding diminishes and pharmacologic thromboprophylaxis may be initiated. For patients at high risk for VTE (Caprini score, >5) in whom both LMWH and UFH are contraindicated or unavailable and who are not at high risk for major bleeding complications, suggest low-dose aspirin, fondaparinux or mechanical prophylaxis, preferably with IPC over no prophylaxis. The patient chart was reviewed and on 8/4/2015 there is an anesthesia record from surgery at which time this is requested. The procedure listed on the anesthesia record states that the procedure was "incision of scar tissue right hand". There is no operative report available. Additionally, a note from 6/24/2015 references an 11 page consultation from 7/30/2014 for utilization review. This document is not provided. Therefore, with the above information and no documentation from the treating physician as to why the IPC devices were requested for this case, the above hand procedure could be considered "reconstructive surgery". However, when the risk for VTE is low, no specific pharmacologic or mechanical thromboprophylaxis is recommended other than early ambulation. There is no documentation as to why the patient referenced above would be at higher risk for VTE with this procedure. Therefore, the prior utilization review is upheld and the IPC devices are not medically necessary.

Retrospective request for DVT (deep vein thrombosis) compression sleeves, quantity: 1 pair, date of service: 08/04/2015: 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), Knee and Leg, (Acute & Chronic): Venous Thrombosis, 2015.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Venous thromboembolism prophylaxis. National Guideline Clearinghouse, From US Dept of Health and Human Services, <https://www.guideline.gov/content.aspx?id=39350>.

Decision rationale: For patients undergoing general, GI, urological, gynecologic, bariatric, vascular, plastic or reconstructive surgery, the 2012 American College of Chest Physicians Clinical Practice guideline recommends the following [Guideline]: For patients at very low risk for VTE (Caprini score, 0), recommend no specific pharmacologic or mechanical thromboprophylaxis be used other than early ambulation. For patients at moderate risk for VTE (Caprini score, 3-4) who are at high risk for major bleeding complications are thought to be particularly severe, suggest mechanical thromboprophylaxis, preferably with IPC, over no prophylaxis. For patients at high risk for VTE (Caprini score, >5) who are not at high risk for major bleeding and for whom complications are thought to be particularly severe, recommend pharmacologic thromboprophylaxis with LMWH or LDUH over no prophylaxis. It is suggested that mechanical thromboprophylaxis with IPC should be added to pharmacologic thromboprophylaxis. For high-VTE-risk patients who are at high risk for major bleeding complications or those in whom the consequences of bleeding are thought to be particularly severe, suggest the use of mechanical thromboprophylaxis, preferably with IPC, over no prophylaxis until the risk of bleeding diminishes and pharmacologic thromboprophylaxis may be initiated. For patients at high risk for VTE (Caprini score, >5) in whom both LMWH and UFH are contraindicated or unavailable and who are not at high risk for major bleeding complications, suggest low-dose aspirin, fondaparinux or mechanical prophylaxis, preferably with IPC over no prophylaxis. The patient chart was reviewed and on 8/4/2015 there is an anesthesia record from surgery at which time this is requested. The procedure listed on the anesthesia record states that the procedure was "incision of scar tissue right hand". There is no operative report available. Additionally, a note from 6/24/2015 references an 11 page consultation from 7/30/2014 for utilization review. This document is not provided. Therefore, with the above information and no documentation from the treating physician as to why the DVT compression sleeves were requested for this case, the above hand procedure could be considered "reconstructive surgery". However, when the risk for VTE is low, no specific pharmacologic or mechanical thromboprophylaxis is recommended other than early ambulation. There is no documentation as to why the patient referenced above would be at higher risk for VTE with this procedure. Therefore, the prior utilization review is upheld and the DVT compression sleeves are not medically necessary.