

Case Number:	CM15-0217665		
Date Assigned:	11/09/2015	Date of Injury:	02/24/2014
Decision Date:	12/29/2015	UR Denial Date:	10/14/2015
Priority:	Standard	Application Received:	11/05/2015

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

Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 2-24-2014. The injured worker was being treated for fracture of the proximal phalanx of the left hallux, laceration of left hallux, crush injury and contusion of left hallux, retained foreign body in left hallux, and painful gait. Treatment to date has included diagnostics, modified work, and medication. On 9-23-2015, the injured worker complains of symptoms of pain and the desire to have the removal of internal fixation. He was pending authorization for surgery for repair of the extensor hallucis longus tendon of the left foot. His work status was modified. He was ambulating in full weight bearing status. Vascular exam noted dorsalis pedis and posterior tibial pulses 2+ of 4 bilaterally and capillary refill time was immediate in digits one through five. His skin temperature was warm to all digits and minimal telangiectasias was present bilaterally. There was a well-healed incision on the dorsal aspect of the left hallux, along with normal skin tone and color. No edema was noted. Current medication regimen was not documented. His past medical history was not detailed. Magnetic resonance imaging of the left foot (7-26-2014) showed metallic artifacts at the medial aspect of base of proximal phalanx of big toe, likely to be iatrogenic, and a small effusion at the tibiotalar joint. Per the Request for Authorization dated 10-08-2015, the treating physician noted that deep vein thrombosis prophylaxis was requested as a preventative measure against the increased likelihood of developing venothromboembolism following surgical procedure. On 10-14-2015 Utilization Review non-certified a request for DVT max and pneumatic compression wraps.

IMR ISSUES, DECISIONS AND RATIONALES

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

DVT max and pneumatic compression wraps: 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.

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 chapter, under Compression Garments.

Decision rationale: The 52 year old patient presents with fracture of the proximal phalanx of the left hallux, laceration of left hallux, crush injury and contusion of left hallux, retained foreign body in left hallux, and painful gait, as per progress report dated 09/23/15. The request is for DVT max and pneumatic compression wraps. The RFA for this case is dated 10/08/15, and the patient's date of injury is 02/24/14. The patient is pending authorization for surgery for repair of the extensor hallucis longus tendon of the left foot, as per progress report dated 09/23/15. The patient has been allowed to work with restrictions, as per progress report dated 09/23/15. ODG guidelines, Knee and Leg chapter, under Compression Garments has the following: Recommended. Good evidence for the use of compression is available, but little is known about dosimetry in compression, for how long and at what level compression should be applied. Low levels of compression 10-30 mmHg applied by stockings are effective in the management of telangiectases after sclerotherapy, varicose veins in pregnancy, the prevention of edema and deep vein thrombosis. High levels of compression produced by bandaging and strong compression stockings -30-40 mmHg- are effective at healing leg ulcers and preventing progression of post-thrombotic syndrome as well as in the management of lymphedema. In a request for authorization letter dated 10/08/15, the treater is requesting for deep vein thrombosis prophylaxis "as a preventive measure against the increased likelihood of developing venothromboembolism (VTE) following a surgical procedure." The request appears reasonable and the use of compression wraps for DVT prophylaxis is supported by the ODG. However, as per progress report dated 09/23/15, the patient is pending authorization for surgery for repair of the extensor hallucis longus tendon of the left foot but there is no indication that this intervention has been authorized. Consequently, the request of DVT compression wraps is not medically necessary.