

Case Number:	CM15-0221646		
Date Assigned:	11/17/2015	Date of Injury:	11/27/2013
Decision Date:	12/30/2015	UR Denial Date:	10/17/2015
Priority:	Standard	Application Received:	11/11/2015

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: Montana

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine

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 34 year old male, who sustained an industrial injury on 11-27-13. Medical records indicate that the injured worker is undergoing treatment for status-post anterior cervical fusion at cervical six-seven, cervical six-seven severe stenosis with cord compression, cervical sprain with radicular symptoms, lumbosacral spine sprain, multilevel cervical disc herniations, multilevel small disc herniations of the thoracic spine and thoracic sprain. The injured workers current work status was not identified. On (6-12-15) the injured worker was noted to be status-post cervical fusion at cervical six-seven. The injured worker reported neck pain rated 7 out of 10 on the visual analog scale. The numbness in his left upper extremity had improved. However, he continued to experience numbness in the right hand and a burning sensation in the right shoulder. The injured worker also noted numbness surrounding the area of the bone graft and ongoing mid and low back pain. Objective findings noted that the injured worker had cervical x-rays performed which were satisfactory. The surgical incision was healing well with no signs of infection. Sutures were removed. Sensation was reduced in the right hand. Left hip incision was healing well with no signs of infection. Sensation was decreased in the intralateral thigh. Treatment and evaluation to date has included medications, cervical x-rays, MRI of the cervical spine (4-14-15), a cervical collar and a anterior cervical fusion on 6-1-15. Current medications include Norco. The current treatment request is for retrospective: Pneumatic compression sequential with caliber pressure rental status-post cervical spine surgery (date of service) 7-1-15- to 8-5-15. The Utilization Review documentation dated 10-17-15 non-certified the request for a retrospective: Pneumatic compression sequential with caliber pressure rental status-post cervical spine surgery (date of service) 7-1-15- to 8-5-15.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective: Pneumatic compression seg with calibr rental post cervical spine surgery DOS: 7/1/15-8/5/15: 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), 2015, Knee and Leg Chapter, 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, Compression garments and Shoulder, Compression garments and Other Medical Treatment Guidelines Published risk factors for DVT by the Centers for Disease Control and Mayo Clinic.

Decision rationale: The MTUS does not address the request for pneumatic compression sequential with caliber pressure rental status-post cervical spine surgery. The DVT unit provides complete compression therapy approved for deep vein thrombosis prophylaxis, edema, lymphedema and venous insufficiency. The ODG guidelines note that there is good evidence for use of compression however there is little known about dosimetry and 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 edema and deep vein thrombosis. Mechanical methods have been shown to be a useful adjunct to anticoagulation therapy in reducing the incidence of DVT. Although mechanical compression does reduce the incidence of DVT to less than that found when prophylaxis is absent, these modalities are generally less effective at producing such reductions than are pharmacologic methods. Shorter lengths of hospital stays make the use of mechanical methods alone ineffective in preventing DVT in the critical weeks after joint replacement. No mechanical prophylaxis method has been shown to reduce the risk of pulmonary embolism or death. The use of DVT intermittent pneumatic compression devices is therefore recommended primarily as an adjunct to anticoagulant-based prophylaxis or in patients who are at high risk of bleeding. No evidence is available however showing efficacy for the DVT compression units greater than standard compression garments. The ODG guidelines do address compression garments in lower extremity orthopedic procedures but not for cervical procedures. The ODG notes that compression garments are not generally recommended in the shoulder. Deep venous thrombosis and pulmonary embolism events are common complications following lower-extremity orthopedic surgery, but they are rare following upper-extremity surgery, especially shoulder arthroscopy. It is still recommended to perform a thorough preoperative workup to uncover possible risk factors for deep venous thrombosis/pulmonary embolism despite the rare occurrence of developing a pulmonary embolism following shoulder surgery. Mechanical or chemical prophylaxis should be administered for patients with identified coagulopathic risk factors. (Edgar, 2012) Although variability exists in the reported incidence of VTE, surgeons should still be aware of the potential for this serious complication after shoulder arthroplasty. (Saleh, 2013) Available evidence suggests a low incidence, but the final decision to consider thrombo-prophylaxis rests with the operating surgeon. (Madhusudhan, 2013) In this case medical record show that he did have an anterior cervical fusion procedure at C6-7. Significant risk factor such as knee replacement, age greater than 60, inherited blood clotting disorder, long periods of bed rest, prolonged sitting without ambulation, cancer, heart failure and a personal or family history of DVT are not documented. There is documentation of obesity however, use of pneumatic

compression devices are not recommended for cervical surgery and there is no justification provided for its use in this case. The request for pneumatic compression sequential with caliber pressure rental status-post cervical spine surgery (date of service) 7-1-15- to 8-5-15 is not medically necessary.