

Case Number:	CM15-0042940		
Date Assigned:	03/13/2015	Date of Injury:	12/02/2012
Decision Date:	04/24/2015	UR Denial Date:	02/17/2015
Priority:	Standard	Application Received:	03/06/2015

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: District of Columbia, Virginia
Certification(s)/Specialty: Internal 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 52 year old male, who sustained an industrial injury on December 2, 2012. He reported a pop in his middle finger and a hyperextension injury to his knee. The injured worker was diagnosed as having osteoarthritis of the lower left leg, osteochondral loose body in the knee, osteochondritis dissecans and sprain of cruciate ligament of the left knee. Treatment to date has included diagnostic studies, surgery, physical therapy and medications. On February 18, 2015, the injured worker complained of constant left knee pain. Symptoms were reported as slight in severity, aching and gradually improving. The symptoms are aggravated by heavy or vigorous physical activity, standing and walking. The symptoms also interfere with his sleep. The treatment plan included medications and a neoprene knee brace. Notes stated that he is need of ongoing medical care as a result of the injury. Possible needs included physician visits, physical therapy, injections and surgery.

IMR ISSUES, DECISIONS AND RATIONALES

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

Wrap & DVT (Deep Vein Thrombosis) Prophylaxis unit: 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 chapter.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Venous thrombosis, ODG (knee and leg chapters), Aetna.com/cpb/medical/data/200_299/0297.html.

Decision rationale: Recommend identifying subjects who are at a high risk of developing venous thrombosis and providing prophylactic measures such as consideration for anticoagulation therapy. Recommendations regarding mechanical prophylaxis differ slightly. According to AAOS, unless contraindicated, mechanical compression should be utilized for both total hip and knee arthroplasty for all patients in the recovery room and during the hospital stay. For patients undergoing THR and TK, ACCP recommends the optimal use of mechanical thromboprophylaxis with the venous foot pump (VFP) or IPC (intermittent pneumatic compression) for patients with high risk of bleeding. When the high bleeding risk decreases, ACCP recommends that pharmacologic thromboprophylaxis be substituted for or added to the mechanical thromboprophylaxis (AAOS/ACCP 2010). The latest AHRQ comparative effectiveness review of VTE in orthopedic surgery conclude that there was inadequate data to make very many recommendations. They did suggest, for patients who have undergone major orthopedic surgery such as hip or knee replacement, extending post surgery use of medications from the standard seven to 10 days to 28 days or longer, to prevent blood clots may be beneficial. While there is not enough evidence to determine which type of anti clotting medication is best, within the heparin class of medications, LMHW was found to superior to unfractionated heparin (Sobieraj 2012). Extended anticoagulation with apixaban or dabigatran reduces recurrent VTE and mortality without increasing major bleeding. Anticoagulation treatment decreases the risk of recurrence but can increase the risk of major bleeding. Anticoagulation treatment for patients with VTE is generally recommended for at least three months, but there is a high risk of recurrence. Extended treatment decreases the risk of recurrence but can increase the risk of major bleeding, so the decision concerning how long to continue anticoagulation can be complicated, especially if patients have unprovoked VTE. Two new trials evaluated the safety and efficacy of extended anticoagulation with either apixaban (AMPLIFY Ext trial) or dabigatran (RE sonate trial). (In the AMPLIFY trial, symptomatic or fatal VTE occurred in one point seven percent of each apixaban group and in 8.8 percent in the placebo group (p less than .001, NNT 20). Clinically relevant bleeding occurred in 6.3 % vs 18% ($p=.001$, NNH 28). But there was no significant difference in the rates of major bleeding. An additional noninferiority trial comparing dabigatran to warfarin showed that rates of recurrent or fatal VTE were similar for the two active drugs, but dabigatran was associated with reduced risk of clinically relevant bleeding (5.6% vs 10.2 %, P LESS than .001, NNT 22) and with a nonsignificant reduction in major bleeding (0.9 percent vs 1.8%) other options for long term prophylaxis against VTE recurrence include rivaroxaban and aspirin. (Agnelli 2013) while current surgical care improvement project measures do not include aspirin as an appropriate sole option for the prevention of VTE, in patients undergoing elective TKA or who have a contradiction to pharmacologic prophylaxis and undergo a THA or HFS, aspirin. In conjunction with compression devices as part of a multimodal approach, would meet these measures. Data do not support the hypothesis that aspirin is less likely to cause adverse bleeding events than more potent anticoagulation (steward 2013). Recent research: based on new studies any mortality advantage for thrombolytics is uncertain, and there is a reasonable concern about increased risk of major bleeding with thrombolytics compared to anticoagulants. This meta analysis shows that adjunctive thrombolytic therapy does not

significantly reduce the risk of mortality or recurrent PE in patients with acute submassive PE, but that adjuvant thrombolytic therapy prevents clinical deterioration requiring the escalation of treatment in patients with acute submassive PE . Bleeding risk assessment might be the most successful approach for improving clinical outcomes and patients' specific benefit. (Nakamura 2014) among patients with associated with lower rates of all caused mortality and increased risk of major bleeding and ICH. (Chatterjee 2014) NSAIDS may almost double the risk for VTE including DVT and PE. NSAIDS should be prescribed with caution, especially in patients at high baseline risk of VTE. Increased VTE risk may come primarily from COX2 inhibitors because aspirin, a COX1 inhibitor, has been shown to be effective in VTE prevention (Ungprasant 2014). Aetna considers active cold compressive therapy units with mechanical pumps and portable refrigerators (e.g. Autochill, gameready , iceman , nanotherm ,vascutherm, protherma) experiments and investigational because they have not been proven to offer clinically significant benefits over passive cold compression therapy units. The patient had surgery in July 2014, a TKA, He is well beyond the post operative period. This intervention would not be needed at this time. Therefore, the request for Wrap & DVT (Deep Vein Thrombosis) Prophylaxis unit is not medically necessary.