

Case Number:	CM15-0120232		
Date Assigned:	06/30/2015	Date of Injury:	01/20/2014
Decision Date:	07/30/2015	UR Denial Date:	06/05/2015
Priority:	Standard	Application Received:	06/22/2015

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: Family Practice

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 is a 42 year old male with a January 20, 2014 date of injury. A progress note dated May 1, 2015 documents subjective complaints (continued pain and stiffness of the bilateral shoulders with decreased range of motion; pain and weakness of the bilateral knees with decreased range of motion; lower back pain with muscle guarding; difficulties with activities of daily living), objective findings (tenderness to palpation over the subacromial regions, acromioclavicular joints, and supraspinatus tendons of the bilateral shoulders; impingement and cross arm tests are positive; crepitus is present; range of motion decreased in all planes; grade 4/5 weakness in all planes; tenderness to palpation over the medial and lateral joint lines of the bilateral knees; positive patellofemoral compression grind test; range of motion of the knees decreased in all planes; tenderness to palpation with muscle guarding and spasm of the lumbar paravertebral musculature, right side greater than left; straight leg raising test elicits increased lower back pain; range of motion asymmetric), and current diagnoses (cervical/trapezial musculoligamentous sprain/strain; thoracic spine musculoligamentous sprain/strain; lumbar spine musculoligamentous sprain/strain; bilateral shoulder periscapular strain/impingement/tendinitis; bilateral knee contusion/sprain/patellofemoral arthralgia/joint effusion/meniscus tear). Treatments to date have included imaging studies, electromyogram of the bilateral upper extremities and the left lower limb that showed evidence of cervical radiculopathy and carpal tunnel entrapment neuropathy of the right wrist, medications, and physical therapy. The treating physician requested authorization for a thirty-day rental of a postoperative deep vein thrombosis compression home unit with bilateral calf sleeves following a left knee arthroscopy.

IMR ISSUES, DECISIONS AND RATIONALES

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

30 day rental of a postoperative DVT compression home unit with bilateral calf sleeves:

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 & leg acute & chronic; compression garment, 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) Chapter: Knee Section: Venous Thromboembolism.

Decision rationale: The Official Disability Guidelines comment on measures to prevent postoperative DVT. These guidelines recommend identifying subjects who are at a high risk of developing venous thrombosis and providing prophylactic measures such as consideration for anticoagulation therapy. Risk for venous thrombosis is higher in those with leg injury combined with family history of venous thrombosis (12-fold risk), Factor V Leiden mutation (50-fold risk), or Factor II 20210A mutation (9-fold risk). Those at high risk should be considered for anticoagulation therapy during the post-hospitalization period. A systematic review looked at 5 types of interventions used to prevent thromboembolism in pelvic and acetabular fracture patients: mechanical compression devices, inferior vena cava filters, low-molecular weight heparins, ultrasound screening, and magnetic resonance venography screening. They concluded that there was limited data to guide which method to choose. Current evidence suggests it is needed for inpatients undergoing many orthopedic-, general-, and cancer-surgery procedures and should be given for at least seven to 10 days. The UK National Institute for Health and Clinical Excellence (NICE) has issued new guidance on the prevention of venous thromboembolism (VTE). They primarily recommend mechanical methods of VTE prophylaxis. Although mechanical methods do reduce the risk of deep vein thrombosis [DVT], there is no evidence that they reduce the main threat, the risk of pulmonary embolism [PE], fatal PE, or total mortality. In contrast, pharmacological methods significantly reduce all of these outcomes. They recommend stockings for prevention of VTE, except in stroke patients. The newer oral anticoagulants rivaroxaban and dabigatran are indicated as treatment options for specific indications, namely hip- and knee-replacement surgery. In the summary of evidence for knee-replacement surgery, under economic considerations, the guidance notes that fondaparinux, dabigatran, low-molecular weight heparin (LMWH), and rivaroxaban were the most cost-effective strategies. ACCP recommends a LMWH or fondaparinux. AAOS, in contrast to ACCP, stratifies patients into four categories based on VTE risk and risk of major bleeding. 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 or TKR, ACCP recommends the optimal use of mechanical thromboprophylaxis with the VFP (venous foot pump) or IPC (intermittent pneumatic compression) for patients with a high risk of bleeding. When the high bleeding risk decreases, ACCP recommends that pharmacologic

thromboprophylaxis be substituted for or added to the mechanical thromboprophylaxis. In this case, there is insufficient evidence to support concerns that the patient is at high-risk for a DVT for a 30 day time period; the timeframe of the request for rental of the DVT compression home unit. While the above cited guidelines support the use of such devices in the hospital setting (and for 7-10 days); there is no evidence to support the need for home use; particularly when it is expected that the patient will be ambulating. Given these concerns, the use of a 30 day rental of a postoperative DVT compression home unit with bilateral calf sleeves is not medically necessary.