

Case Number:	CM14-0014891		
Date Assigned:	02/28/2014	Date of Injury:	07/31/2013
Decision Date:	08/04/2014	UR Denial Date:	01/29/2014
Priority:	Standard	Application Received:	02/05/2014

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. The expert reviewer is Board Certified in Occupational Medicine and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 54-year-old male with a date of injury of 7/31/13. The mechanism of injury was due to a lifting and twisting of a heavy object. He felt a pinch in his left shoulder and his low back was sore. On 1/21/14 he complained of left shoulder pain and low back pain radiating into the bilateral buttocks. Exam revealed swelling over the bilateral shoulders and, tenderness over the left shoulder, with restricted range of motion. The diagnostic impression is left shoulder sprain/strain and LS sprain/strain. Treatment to date includes physical therapy and medication management. A UR decision dated 1/29/14, denied the request for a pneumatic compression device. Guideline criteria have not been met as there is no documentation indicating this patient is at a significantly increased risk for a DVT and/or cannot utilize a compression hose

IMR ISSUES, DECISIONS AND RATIONALES

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

POST-OPERATIVE DME: PNEUMATIC INTERMITTENT COMPRESSION DEVICE
QTY: 1.00: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Forearm, Wrist & Hand, Vasopneumatic Device.

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.

Decision rationale: California MTUS does not specifically address this issue. ODG states that continuous-flow cryotherapy is recommended as an option after surgery, but not for nonsurgical treatment. Postoperative use generally may be up to 7 days, including home use. However, ODG states that while there are studies on continuous-flow cryotherapy, there are no published high quality studies on the [REDACTED] device or any other combined system. There is no rationale identifying why a cryotherapy unit would be insufficient. There are no established risk factors for DVT. However, from the documentation provided, it is unclear why this patient needs a vasocompressive device. The guidelines do not support intermittent compressive devices unless there is a clear description of a risk of DVT. This patient is documented to have shoulder surgery and there should not be any difficulties with ambulation. Therefore, the request for post-operative DME: Pneumatic Intermittent Compressive Device was not medically necessary.