

<b>Case Number:</b>	CM14-0017193		
<b>Date Assigned:</b>	04/14/2014	<b>Date of Injury:</b>	11/17/2013
<b>Decision Date:</b>	05/30/2014	<b>UR Denial Date:</b>	01/30/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/11/2014

### 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 Physical Medicine & Rehabilitation and is licensed to practice in Illinois. 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:

The injured worker is a 32 year old male who reported an injury after a slip and fall down a set of stairs. The injured worker reportedly injured his left shoulder. The injured worker participated in a period of conservative care that failed to resolve the injured worker's symptoms. The injured worker underwent an MRI that documented there was a capsular injury, and a labrum from the superior to the anteroinferior margin of the labrum. The injured worker was evaluated on 01/10/2014. It was documented that the injured worker continued to have left shoulder pain rated at a 4/10. Physical findings included restricted range of motion of the left shoulder with tenderness to palpation over the glenohumeral joint. The injured worker's diagnoses included post anterior interior shoulder dislocation with type 3 superior labrum tear of the left shoulder. Surgical intervention was recommended. The request was made for compression therapy. No justification for the request was provided.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**DME: COMPRESSION THERAPY:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Treatment In Worker's Comp 18th Edition, 2013 Updates, Shoulder Chapter - Cold Compression Therapy.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Shoulder Chapter, Venous Stasis and Continuous Flow Cryotherapy.

**Decision rationale:** The requested DME compression therapy is not medically necessary or appropriate. The request as it is submitted does not clearly identify what type of equipment is being requested. California Medical Treatment Utilization Schedule does not address durable medical equipment. Official Disability Guidelines do not support the use of compression therapy for injured workers who are not at risk for developing deep vein thrombosis. The inherent risk of developing deep vein thrombosis is significantly less in upper extremity surgeries. Therefore, the need for compression therapy is not clearly identified within the documentation. Additionally, Official Disability Guidelines state that continuous-flow cryotherapy is appropriate for up to 7 days in the management of postsurgical pain. However, the request as it is written does not clearly identify the equipment being requested or the appropriateness of the request itself cannot be determined. As such, the requested DME compression therapy is not medically necessary or appropriate.