Case Number:	CM14-0112027		
Date Assigned:	08/01/2014	**Date of Injury:**	02/04/2013
Decision Date:	09/22/2014	**UR Denial Date:**	06/26/2014
Priority:	Standard	**Application Received:**	07/18/2014

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 Pain Medicine and is licensed to practice in Texas and Ohio. 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 38 year old female who reported an injury on 02/04/2013; the mechanism of injury was due to repetitive lifting. Diagnoses included superior glenoid labrum lesions (SLAP), impingement, lateral epicondylitis of the elbow, and bilateral carpal tunnel syndrome. Past treatments included physical therapy, cold/heat therapy, electrical stimulation, home exercise program and medications. Diagnostic studies included an x-ray of the left shoulder and an MRI of the left shoulder. A complete blood count was collected on 02/19/2014, which indicated hemoglobin of 12.9 and hematocrit of 38.3. Surgical history included a left shoulder arthroscopic subacromial decompression and debridement on 03/05/2014. The clinical note dated 02/19/2014 stated the injured worker complained of pain in the left shoulder. Physicial exam findings of the left shoulder indicated limited range of motion. The O'Brien's test was said to be unreliable due to pain. Medications included vicodin and ibuprofen. The treatment plan included an intermittent limb compression device; the rationale for treatment was not provided. The request for authorization was submitted on 03/05/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective request for intermittent limb compression device, DATE OF SERVICE: 03/05/2014: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Intergrated Treatment/Disability Duration Guidelines, Knee & Leg (Acute & Chronic).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG) Shoulder, Compression garments.

Decision rationale: The injured worker had a left shoulder arthroscopic subacromial decompression and debridement on 03/05/2014. The Official Disability Guidelines indicate that compression garments are not generally recommended in the shoulder because deep vein thrombosis and pulmonary embolism events are rare following upper extremity surgery, especially shoulder arthroscopy. A complete blood count was collected prior to surgery indicating that hemoglobin and hematocrit levels were within normal limits. There is no other clinical documentation to indicate that the injured worker was at risk for a venous thrombosis. The requesting physician's rationale for the request is not indicated within the provided documentation. Additionally, the guidelines note compression is generally not recommended following upper extremity surgery. Therefore the retrospective request for an intermittent limb compression device is not medically necessary and appropriate.