MAXIMUS Federal Services

Case Number:	CM14-0180506		
Date Assigned:	11/05/2014	Date of Injury:	08/12/2010
Decision Date:	12/12/2014	UR Denial Date:	10/21/2014
Priority:	Standard	Application Received:	10/30/2014

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 Orthopedic Surgeon 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:

The injured worker is a 55-year-old female who reported an injury on 08/12/2012. The injured worker sustained injuries while she was pulling a microwave off the shelf and the weight shifted, as she turned her left shoulder and neck. The Injured worker's treatment history included medications, left shoulder surgery, and MRI studies of the right shoulder. On 03/12/2014, the injured worker had undergone a standard arthroscopic procedure. Within the report on 03/12/2014, it was documented an unofficial MRI scan demonstrated a rotator cuff tear, calcific tendinitis, biceps tendinosis, AC joint arthritis, and labral tear. The arthroscopic findings revealed normal appearing biceps tendon; the superior labrum was torn. The subscapularis had a tear of the upper border. Subscapularis recess was normal. The anterior glenohumeral ligaments were intact. The axillary fold was clear. There was tearing of the anterior inferior labrum from the 3 o'clock to the 6 o'clock position. The posterior labrum was normal. The articular surfaces were smooth. There was no Hill-Sachs or Bankart lesion present. There was a full thickness rotator cuff tear involving supraspinatus and infraspinatus tendons. The subacromial had marked inflammation and fibrosis in the subacromial bursa. There were abrasion changes on the undersurface of the tip of the acromion which had a bony prominence. The AC joint had inferior osteophytes with abrasion changes. There was a full thickness rotator cuff tear involving the supraspinatus and infraspinatus tendons with minimal retraction. There was a 1 cm extension in the tendon posterior and 1 cm extension in the rotator interval anteriorly. The Request for Authorization was not submitted for this review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Pressure pneumatic appl half leg: 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)

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder, Venous Thrombosis

Decision rationale: The request for pressure pneumatic appl half leg is not medically necessary. The Official Disability Guidelines recommends venous thrombosis is recommended monitoring risk of perioperative thromboembolic complications in both the acute and sub acute postoperative periods for possible treatment, and identifying subjects who are at a high risk of developing venous thrombosis and providing prophylactic measures such as consideration for anticoagulation therapy. In the shoulder, risk is lower than in the knee and depends on: (1) invasiveness of the surgery (uncomplicated shoulder arthroscopy would be low risk but arthroplasty would be higher risk); (2) the postoperative immobilization period; & (3) use of central venous catheters. Upper extremity deep vein thrombosis (UEDVT) may go undetected since the problem is generally asymptomatic. The incidence of UEDVT is much less than that of the lower extremity DVT possibly because: (a) fewer, smaller valves are present in the veins of the upper extremity, (b) bedridden patients generally have less cessation of arm movements as compared to leg movements, (c) less hydrostatic pressure in the arms, & (d) increased fibrinolytic activity that has been seen in the endothelium of the upper arm as compared to the lower arm. It is recommended to treat patients of asymptomatic mild UEDVT with anticoagulation alone and patients of severe or extensive UEDVT with motorized mechanical devices in conjunction with pharmacological thrombolysis, without delay beyond 10-14 days. Upper extremity DVT is much less studied compared to lower extremity DVT and the diagnostic and therapeutic modalities still have substantial areas that need to be studied. Although it is generally believed that venous thromboembolism (VTE) after shoulder surgery is very rare, there are increasing reports of deep venous thrombosis (DVT) and pulmonary embolism (PE) associated with shoulder surgery. For patients who score one point or less, the initial test of the algorithm is a serum D-dimer which if negative can rule out DVT. If the D-dimer is elevated, then a compression ultrasound is done. For patients with a score of 2 or 3, the algorithm starts with a compression ultrasound. If that is positive, DVT is diagnosed, but if negative, a D-dimer test is also obtained to confirm the absence of DVT. There is inadequate data from controlled studies demonstrating any change in this rare complication with or without the durable medical equipment (DME) that was provided. As such the request for pressure pneumatic appl half leg is not medically necessary.