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| <b>Case Number:</b>   | CM14-0024908 |                              |            |
| <b>Date Assigned:</b> | 06/11/2014   | <b>Date of Injury:</b>       | 05/27/2010 |
| <b>Decision Date:</b> | 07/18/2014   | <b>UR Denial Date:</b>       | 01/29/2014 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 02/27/2014 |

### 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 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 51-year-old female who reported an injury on 05/07/2010. Her diagnoses were noted to be closed head trauma; cervical spine strain/sprain, rule out discopathy; bilateral lateral epicondylitis, right greater than left; right knee internal derangement; right shoulder sprain/strain; and right shoulder impingement syndrome. Her previous treatments are not indicated in the documents submitted for this review. In a progress report with date of exam being 03/13/2014, objective findings are as follows: Finkelstein's testing was positive, bilaterally; right greater than left. Tinel's sign was positive at the wrists, bilaterally; right greater than left. Cervical spine had pain and tenderness, more right than left-sided with limited right rotation and extension. Head compression testing was negative. Right shoulder had pain and tenderness over the anterior and lateral deltoids. Range of motion testing produced pain. There was positive impingement, positive Neer's. Right knee had full range of motion. There was joint line tenderness, more medially than laterally. There was a positive Tinel's over the right wrist. There was positive Finkelstein's maneuver over the right hand. Left hand had positive Finkelstein's maneuver as well. Bilateral elbows had full range of motion with positive Tinel's in the ulnar groove. Left elbow had full range of motion with tenderness in the medial epicondyle as well as Tinel's in the ulnar groove. There was pain and tenderness in the bilateral basilar joints of the thumbs. The treatment plan included a followup treatment with shoulder and knee specialist, a psychiatric evaluation, and medication Klonopin to treat panic and anxiety as well as transdermal medications prescribed for minimizing pain and avoiding side effects of some oral medications. The request for authorization of medical treatment is not provided within the documentation. The provider's rationale for the request was not provided within the documentation.

## IMR ISSUES, DECISIONS AND RATIONALES

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

### **RETROSPECTIVE REQUEST FOR 1 PNEUMATIC INTERMITTENT COMPRESSION DEVICE (DURATION 1-30 DAYS) BETWEEN 07/19/2013 AND 08/19/2013: 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), Shoulder (Acute & Chronic), Cold Compression Therapy.

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

**Decision rationale:** The retrospective request for one pneumatic intermittent compression device (duration 1-30 days) between 07/19/2013 and 08/19/2013 is not medically necessary. The Official Disability Guidelines recommend lymphedema pumps for home use as an option for the treatment of lymphedema after a 4-week trial of conservative medical management including exercise, elevation, and compression garments. The injured worker is documented to have had right shoulder surgery on 07/19/2013. The documentation submitted with this review does not provide adequate postoperative information to support that the injured worker had a 4-week trial of conservative medical management including exercise, elevation and compression garments. The provider's request fails to indicate exactly where the compression device is to be used within the request. Therefore, due to lack of appropriate documentation to support this retrospective request the retrospective request for one pneumatic intermittent compression devices (duration 1-30 days) between 07/19/2013 and 08/19/2013 is not medically necessary.

### **RETROSPECTIVE REQUEST FOR 2 SEGMENTAL GRADIENT PRESSURE PNEUMATIC APPLIANCES (DURATION 1-30 DAYS) BETWEEN 07/19/2013 AND 08/19/2013: 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), Shoulder (Acute & Chronic), Cold Compression Therapy.

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

**Decision rationale:** The retrospective request for two segmental gradient pressure pneumatic appliances (duration 1-30 days) between 07/19/2013 and 08/19/2013 is not medically necessary. As the pneumatic intermittent compression device is not medically necessary, so is the pneumatic appliance not medically necessary.

