

<b>Case Number:</b>	CM14-0062891		
<b>Date Assigned:</b>	07/11/2014	<b>Date of Injury:</b>	02/28/2013
<b>Decision Date:</b>	09/12/2014	<b>UR Denial Date:</b>	04/16/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/05/2014

### 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, 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 63-year-old male who reported an injury on 02/28/2013 due to an unspecified mechanism of injury. A clinical document dated 04/08/2014 showed that the injured worker was to undergo an arthroscopy and limited debridement to the shoulder with a biceps tenomyotomy. Her diagnoses included osteoarthritis of the shoulder, SLAP lesion and shoulder pain. Information regarding subjective complaints and objective exam, surgical history, medications and past treatment was not provided for review. The treatment plan was for an inter-limb compression device not otherwise specified. The Request for Authorization form was signed on 04/18/2014. The rationale for treatment was not provided.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Intermittent limb compression device:** 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, Cold compression therapy.

**Decision rationale:** A Surgical Scheduling form dated 04/08/2014 showed that the injured worker was to undergo surgery to the right shoulder. The California MTUS/ACOEM Guidelines do not address intermittent limb compression devices. The Official Disability Guidelines state that cold compression therapy is not recommended in the shoulder as there are no published studies, but may be recommended as an option for other body parts. Based on the clinical information submitted for review, the injured worker was to undergo surgery to the shoulder. There was no rationale given for the necessity of an intermittent limb compression device, and therefore the request is unclear. In addition, cold compression therapy is not recommended in the by the guidelines for the shoulder. And therefore would not be supported. Given the above, the request for intermittent limb compression device is not medically necessary and appropriate.