MAXIMUS Federal Services

| Case Number: | CM14-0077604 | | |
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| Date Assigned: | 07/18/2014 | Date of Injury: | 03/01/2010 |
| Decision Date: | 10/08/2014 | UR Denial Date: | 05/14/2014 |
| Priority: | Standard | Application Received: | 05/27/2014 |

## 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 and 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:

This 52 year-old patient sustained an injury on 3/1/10 while employed by [redacted] Request(s) under consideration include intermittent limb compression device. The patient underwent right forearm hardware removal on 4/1/14. Report of 2/26/14 from the provider noted the patient with ongoing right shoulder and wrist pain; takes Tramadol to relief pain. Past medical history include asthma, hypertension, cubital tunnel syndrome, anxiety, and depression. Past surgical history include left distal radius fracture as a child; history of biopsies and right shoulder arthroscopies. Medications list Celexa, Wellbutrin, Zyrtec, Buspar, Amlodipine, Trazadone, Ativan, Protonix, Acyclovir, Tramadol, Amiloride, Albuterol inhaler. Exam showed right shoulder with limited range of flex/abd/ER/ IR of 160/150/70/30 degrees; positive impingement; tenderness over biceps; normal right elbow range; negative Tinel's at elbow and wrist; negative compression test; intact sensation without evidence of thenar atrophy. Diagnoses include TFCC right wrist s/p debridement; right ulnar impaction syndrome s/p open ulnar shortening with delayed healing; right wrist and forearm tendinitis; retained hardware of right forearm; right shoulder SLAP s/p repair; and right AC joint arthritis s/p excision of distal clavicle. Treatment plan included right forearm hardware removal. The request(s) for intermittent limb compression device was denied on 5/14/14 citing guidelines criteria and lack of medical necessity.

## 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, shoulder chapter, venous thrombosis

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Venous Thrombosis, pages 356-358

**Decision rationale:** The compression system delivers pneumatic compression via wraps aiding venous return. During the weeks following surgery, mobility is an issue, making the compression unit necessary in preventing any risk of DVT developing while being immobile for multiple hours at a time. The device provides DVT prophylaxis for post-operative orthopedic patients. The patient underwent right forearm hardware removal surgery; however, the provider does not identify specific risk factors for DVT prophylaxis. Per Guidelines, although DVT prophylaxis is recommended to prevent veno-thromboembolism (VTE) for patient undergoing knee or hip arthroplasty, it is silent on its use for forearm hardware removal surgery. Some identified risk factors identified include lower limb surgeries, use of hormone replacement therapy, chronic smoking history and obesity, none of which apply in this case. Submitted reports have not demonstrated factors meeting criteria especially rehabilitation to include mobility and exercise are recommended post-upper extremity surgical procedures as a functional restoration approach towards active recovery. Submitted reports have not adequately demonstrated indication, clinical findings, post-operative complications, or co-morbidities to support the system beyond guidelines criteria. The intermittent limb compression device is not medically necessary and appropriate.