

<b>Case Number:</b>	CM14-0207794		
<b>Date Assigned:</b>	12/19/2014	<b>Date of Injury:</b>	10/15/2013
<b>Decision Date:</b>	03/16/2015	<b>UR Denial Date:</b>	11/26/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/11/2014

### 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: California, Arizona

Certification(s)/Specialty: Physical Medicine & Rehabilitation

### 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 69-year-old male who reported an injury on 10/15/2013. The mechanism of injury was not provided. On 08/14/2014, the injured worker presented with no acute distress. Diagnoses for left shoulder impingement syndrome, acromioclavicular joint arthritis and mild glenohumeral arthritis. Upon examination of the left shoulder, the range of motion values were 140 degrees of flexion, 70 degrees of external rotation, 30 degrees of extension and 30 degrees of internal rotation. There was normal sensation and no muscle atrophy. There was 2+ tenderness over the acromioclavicular joint and 3+ impingement sign with 4/5 strength. Prior therapies included medications, activity modification, physical therapy and injections. The provider recommended a DVT intermittent pneumatic compression device. The provider's rationale was not provided. The Request for Authorization form was not included in the medical documents for review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**DVT Intermittent Pneumatic 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) Knee Chapter

**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 a DVT intermittent pneumatic compression device is not medically necessary. Official Disability Guidelines recommend monitoring risks of preoperative thromboembolic complications in both the acute and subacute postoperative period for possible treatment, identifying subjects who are at high risk of developing venous thrombosis and providing prophylactic measures, such as consideration for anticoagulation therapy. The documentation submitted for review lacks evidence of the injured worker being at a moderate to high risk for venous thrombosis. There was no rationale provided. Additionally, the provider's request does not indicate the body part at which the DVT intermittent pneumatic compression device was indicated for in the request as submitted. As such, medical necessity has not been established.