

<b>Case Number:</b>	CM15-0131008		
<b>Date Assigned:</b>	08/10/2015	<b>Date of Injury:</b>	02/05/1996
<b>Decision Date:</b>	09/04/2015	<b>UR Denial Date:</b>	06/01/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/07/2015

### 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, Oregon, Washington  
 Certification(s)/Specialty: Orthopedic Surgery

### 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 is a 63 year old female with a February 5, 1996 date of injury. A progress note dated May 6, 2015 documents subjective complaints (right and left shoulder pain and stiffness), objective findings (tenderness of the right shoulder; decreased range of motion of the right shoulder secondary to pain; cross chest adduction test of the right shoulder positive; positive Neer's, Hawkins, and O'Brien tests of the right shoulder; diffuse tenderness of the left shoulder; decreased range of motion of the left shoulder secondary to pain; cross chest adduction test of the left shoulder positive; positive Neer's, Hawkins, and O'Brien tests of the left shoulder), and current diagnoses (bilateral shoulder pain; acromioclavicular arthritis; impingement syndrome; labral tear, shoulder). Treatments to date have included x-rays of the bilateral shoulders that showed acromioclavicular arthrosis, medications, and physical therapy. The treating physician documented a plan of care that included a surgical assistant for left shoulder surgery, deep vein thrombosis, and Polar Care for the shoulder.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Associated Service: DVT (Deep Vein Thrombosis): Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, 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) Shoulder section.

**Decision rationale:** CA MTUS/ACOEM is silent on compression garments for DVT prophylaxis. According to ODG, Shoulder section, Compression garments, "Not generally recommended in the shoulder. Deep venous thrombosis and pulmonary embolism events are common complications following lower-extremity orthopedic surgery, but they are rare following upper-extremity surgery, especially shoulder arthroscopy. It is still recommended to perform a thorough preoperative workup to uncover possible risk factors for deep venous thrombosis/ pulmonary embolism despite the rare occurrence of developing a pulmonary embolism following shoulder surgery. Mechanical or chemical prophylaxis should be administered for patients with identified coagulopathic risk factors." In this case, there is no evidence of risk factor for DVT in the provided clinical records from 5/6/15. Therefore, the determination is for non-certification for the DVT compression garments; the request is not medically necessary.

**Associated Service: Polar care Shoulder:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Shoulder Chapter Continuous-flow cryotherapy.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Shoulder Chapter, Continuous flow cryotherapy.

**Decision rationale:** CA MTUS/ACOEM is silent on the issue of shoulder cryotherapy. According to ODG Shoulder Chapter, Continuous flow cryotherapy, it is recommended immediately postoperatively for upwards of 7 days. In this case, there is no specification of length of time requested postoperatively for the cryotherapy unit. Therefore, the request is not medically necessary and the determination is for non-certification.

**Associated Service: Surgical Assistant:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Low Back Chapter, Surgical Assistant.

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

**Decision rationale:** CA MTUS/ACOEM is silent on the issue of a surgical assistant. ODG low back is referenced. More complex cases based off CPT code are felt to warrant the use of a surgical assistant. The requested procedure is shoulder arthroscopy with subacromial decompression, distal clavicle excision and possible SLAP repair. Given the level of complexity of the surgery, it is not medically necessary to have an assistant.