

<b>Case Number:</b>	CM15-0185329		
<b>Date Assigned:</b>	09/25/2015	<b>Date of Injury:</b>	03/17/2013
<b>Decision Date:</b>	11/06/2015	<b>UR Denial Date:</b>	09/11/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/21/2015

### 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: Iowa, Illinois, California

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine, Public Health & General Preventive Medicine

### 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 27 year old female, who sustained an industrial injury on 3-17-2013. The injured worker was being treated for left shoulder pain and major depressive affective disorder, single episode, severe, without mention of psychotic behavior. Treatment to date has included diagnostics, physical therapy, acupuncture, cortisone injection, psychological treatment, and medications. On 8-06-2015, it was documented in the psychological progress notes that the injured worker attempted suicide on 8-03-2015, taking 30 pills of Zoloft, because her pain was so intense. Magnetic resonance imaging of the left shoulder with arthrogram (4-24-2015) showed supraspinatus and infraspinatus partial tendon tears and down-sloping of the anterior acromion resulting in narrowing of the acromiohumeral interval (6.4mm). The treating physician noted that she was to undergo left shoulder arthroscopic decompression with acromioplasty, rotator cuff debridement versus repair, and distal clavicle resection surgery on 9-09-2015. The treating physician documented that there was a higher risk of developing deep vein thrombosis due to the type of surgery combined with other risk factors, noting "history of a respiratory condition". The respiratory condition was not specified. The treatment plan included post-operative deep vein thrombosis home unit with bilateral calf sleeves (30 day rental), non-certified by Utilization Review on 9-11-2015.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Post-operative DVT comprehensive home unit with bilateral calf sleeve (30-day rental):**  
Upheld

**Claims Administrator guideline:** Decision based on MTUS Shoulder Complaints 2004, and Chronic Pain Medical Treatment 2009, and Postsurgical Treatment 2009. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder Chapter.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee and Leg, Venous Thrombosis and Compression Therapy and Other Medical Treatment Guidelines [http://www.thermotekusa.com/md\\_vascutherm.php](http://www.thermotekusa.com/md_vascutherm.php).

**Decision rationale:** MTUS is silent concerning compression therapy. ODG States "Recommended. Good evidence for the use of compression is available, but little is known about dosimetry in compression, for how long and at what level compression should be applied. Low levels of compression 10-30 mmHg applied by stockings are effective in the management of telangiectases after sclerotherapy, varicose veins in pregnancy, the prevention of edema and deep vein thrombosis (DVT). High levels of compression produced by bandaging and strong compression stockings (30-40 mmHg) are effective at healing leg ulcers and preventing progression of post-thrombotic syndrome as well as in the management of lymphedema. (Partsch, 2008) (Nelson-Cochrane, 2008) See also Lymphedema pumps; Venous thrombosis." MTUS is silent concerning DVT prophylaxis. ODG states "Recommend identifying subjects who are at a high risk of developing venous thrombosis and providing prophylactic measures such as consideration for anti-coagulation therapy. Minor injuries in the leg are associated with greater risk of venous thrombosis. The relative risk for venous thrombosis is 3-fold greater following minor injury, especially if injury occurs in the 4 weeks prior to thrombosis, is located in the leg, and involves multiple injuries or rupture of muscle or ligament. Risk for venous thrombosis is higher in those with leg injury combined with family history of venous thrombosis (12-fold risk), Factor V Leiden mutation (50-fold risk), or Factor II 20210. A mutation (9-fold risk). (van Stralen, 2008) A venous thrombosis is a blood clot that forms within a vein. Deep venous thromboses (DVTs) form in the deep veins of the legs, and if a piece of a blood clot formed in a vein breaks off it can be transported to the right side of the heart, and from there into the lungs, and is called an embolism, and this process called a venothromboembolism (VTE). Risk factors for venous thrombosis include immobility, surgery, and prothrombotic genetic variant." Neither AAOS nor ACCP recommend routine screening for DVT or PE in asymptomatic patients postoperatively. Warfarin is an acceptable therapy in all patient groups, but recommendations regarding other medications differ. ACCP recommends a LMWH or fondaparinux. AAOS, in contrast to ACCP, stratifies patients into four categories based on VTE risk and risk of major bleeding. Recommendations regarding mechanical prophylaxis differ slightly. According to AAOS, unless contraindicated, mechanical compression should be utilized for both total hip and knee arthroplasty for all patients in the recovery room and during the hospital stay. For patients undergoing THR or TKR, ACCP recommends the optimal use of mechanical thromboprophylaxis with the VFP (venous foot pump) or IPC (intermittent pneumatic compression) for patients with a high risk of bleeding. When the high bleeding risk decreases, ACCP recommends that pharmacologic thromboprophylaxis be substituted for or added to the mechanical thromboprophylaxis. (AAOS/ACCP, 2010) The latest AHRQ Comparative Effectiveness Review of venous thromboembolism in orthopedic surgery concluded that there are inadequate data to make very many recommendations. They did suggest, for patients who have undergone major orthopedic surgery such as hip or knee replacement, extending post-surgery use of medications, from the standard 7-10 days to 28 days or longer, to prevent blood clots may be beneficial. While there is not enough evidence to determine which

type of anti-clotting medication is best, within the heparin class of medications, low molecular-weight heparin was found to be superior to unfractionated heparin. (Sobieraj, 2012) Extended anticoagulation with apixaban or dabigatran reduces recurrent VTE and mortality without increasing major bleeding. While DVT prophylaxis is appropriate for surgical patients, the treating physician has not provided documentation as to why compression therapy is needed in addition to anti-coagulation therapy. The treating physician does note a respiratory condition but does not fully detail how this condition makes the patient high risk for a DVT and why the compression device is needed in addition to anticoagulation therapy. As such, the request for Post-operative DVT comprehensive home unit with bilateral calf sleeve (30-day rental) is not medically necessary.