

<b>Case Number:</b>	CM15-0038874		
<b>Date Assigned:</b>	03/09/2015	<b>Date of Injury:</b>	07/25/2003
<b>Decision Date:</b>	05/06/2015	<b>UR Denial Date:</b>	02/02/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/02/2015

### 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

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

### 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 54 year old male, who sustained an industrial injury on July 25, 2003. The injured worker had reported left shoulder pain. The diagnoses have included left shoulder supraspinatus muscle/tendon strain and impingement syndrome, acromioclavicular joint sprain and left shoulder partial-thickness supraspinatus tendon tear. Treatment to date has included medications, radiological studies, physical therapy and left shoulder surgery. Current documentation dated January 30, 2015 notes that the injured worker was ten days post-operative for left shoulder surgery. The injured worker reported pain and a limited range of motion of the left shoulder. Physical examination of the left shoulder revealed intact incisions, crepitus in the subacromial space and a limited range of motion. The treating physician's plan of care included a request for deep vein thrombosis prophylaxis with intermittent limb therapy for thirty days related to left shoulder supraspinatus muscle/tendon strain and impingement syndrome as an outpatient.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Deep vein thrombosis prophylaxis with intermittent limb therapy for 30 days:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

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

**Decision rationale:** With regard to this request for a DVT prophylaxis device following shoulder surgery, the ODG Shoulder Chapter states the following regarding venous thrombosis: "Recommend monitoring risk of perioperative thromboembolic complications in both the acute and subacute postoperative periods for possible treatment, and identifying subjects who are at a high risk of developing venous thrombosis and providing prophylactic measures such as consideration for anticoagulation therapy. In the shoulder, risk is lower than in the knee and depends on: (1) invasiveness of the surgery (uncomplicated shoulder arthroscopy would be low risk but arthroplasty would be higher risk); (2) the postoperative immobilization period; & (3) use of central venous catheters. Upper extremity deep vein thrombosis (UEDVT) may go undetected since the problem is generally asymptomatic. The incidence of UEDVT is much less than that of the lower extremity DVT possibly because: (a) fewer, smaller valves are present in the veins of the upper extremity, (b) bedridden patients generally have less cessation of arm movements as compared to leg movements, (c) less hydrostatic pressure in the arms, & (d) increased fibrinolytic activity that has been seen in the endothelium of the upper arm as compared to the lower arm. It is recommended to treat patients of asymptomatic mild UEDVT with anticoagulation alone and patients of severe or extensive UEDVT with motorized mechanical devices in conjunction with pharmacological thrombolysis, without delay beyond 10-14 days. Upper extremity DVT is much less studied compared to lower extremity DVT and the diagnostic and therapeutic modalities still have substantial areas that need to be studied. (Saseedharan, 2012) Although it is generally believed that venous thromboembolism (VTE) after shoulder surgery is very rare, there are increasing reports of deep venous thrombosis (DVT) and pulmonary embolism (PE) associated with shoulder surgery. (Ojike, 2011) Deep vein thrombosis (DVT) has an incidence of 1 case per 1000 and it is very rare after arthroscopy of the shoulder. The administration of DVT prophylaxis is not generally recommended in shoulder arthroscopy procedures. (Garofalo, 2010) On the other hand, the prevalence of DVT after reconstructive shoulder arthroplasty was 13%, compared to 27% after knee arthroplasty. (Willis, 2009)" In the case of this injured worker, there is no documentation of an extenuating circumstance that would warrant DVT prophylaxis. A note from 1/13/15 indicates that arthroscopic surgery will be performed but no extenuating risk factors have been identified and the ODG specifically recommend against routine prophylaxis in arthroscopic shoulder surgery. Furthermore, there is no indication as to why anticoagulation would be contraindicated as this is a more consistent form of prophylaxis than mechanical devices. This request is not medically necessary.