

<b>Case Number:</b>	CM13-0037396		
<b>Date Assigned:</b>	12/13/2013	<b>Date of Injury:</b>	02/01/2013
<b>Decision Date:</b>	02/26/2014	<b>UR Denial Date:</b>	10/16/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/23/2013

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Orthopedic Surgery and is licensed to practice in Texas. 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 physician 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:

The patient is a 44-year-old male who reported an injury on 02/01/2013. The mechanism of injury was not provided for review. The patient reportedly sustained an injury to the right shoulder that was recalcitrant to conservative treatment and ultimately resulted in arthroscopic surgical repair on 10/17/2013. The patient's most recent clinical examination findings included a well-healed incision without evidence of infection. It was noted that the sutures were removed at that time. The patient's diagnoses included status post rotator cuff tear of the right shoulder and status post arthroscopic surgical intervention of the right shoulder. The patient's treatment plan included the continuation of physical therapy and medication management for pain control.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Vacutherm cold compression unit, 28 days rental:** 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)

**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, Continuous Flow Cryotherapy

**Decision rationale:** The requested VacuTherm cold compression unit for a 28 day rental is not medically necessary or appropriate. The Official Disability Guidelines do recommend the use of a continuous flow cryotherapy unit for up to 7 days in the postsurgical treatment of a patient's pain management. The clinical documentation submitted for review does provide evidence that the patient underwent surgical intervention and may benefit from a continuous flow cryotherapy unit. However, the request exceeds the guideline recommendations. There were no exceptional factors noted within the documentation to support extending treatment beyond the guideline recommendations. As such, the requested VacuTherm cold compression unit for a 28 day rental is not medically necessary or appropriate.