

<b>Case Number:</b>	CM15-0194403		
<b>Date Assigned:</b>	10/08/2015	<b>Date of Injury:</b>	01/02/2013
<b>Decision Date:</b>	11/16/2015	<b>UR Denial Date:</b>	09/15/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/02/2015

### 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: Illinois, California, Texas  
 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 injured worker is a 66-year-old male who sustained an industrial injury on 1/2/13. A specific mechanism of injury was not documented. Past medical history was reported positive for low back and prostate issues, both treated with medication. The 5/31/14 right shoulder MRI impression documented an extensive labral tear involving the entire superior labrum extending posteriorly to involve the entire posterior labrum with associated paralabral cysts. There was moderate grade chondral cartilage loss of the humeral head most conspicuous inferiorly and anteriorly. There was a low-grade intrasubstance tear of the subscapularis tendon, and mild to moderate supraspinatus and infraspinatus tendinosis. The 9/10/15 treating physician report cited right shoulder pain and numbness along the dorsoradial aspect of his right wrist and right shoulder pain. Right upper extremity exam documented positive O'Brien's, pain with resisted flexion, anterior glenohumeral joint line tenderness, positive Tinel's over the superficial branch of the radial nerve, and intact right palmar hand sensation. The diagnosis was right shoulder labral tear and Wartenberg syndrome, right forearm. Authorization was requested for right shoulder arthroscopy with associated surgical services including assistant surgeon, 12 visits of post-op physical therapy and VascuTherm 4 for 21 days. The 9/15/15 utilization review certified the requests for right shoulder arthroscopy, assistant surgeon, and 12 visits of post-op physical therapy. The request for a VascuTherm 4 for 21 days was non-certified as guidelines do not recommend compression or cold compression therapy for the shoulder and there was no rationale or medical justification presented to contravene the guidelines recommendations.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Associated surgical service: Vascutherm 4 x 21 Days:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Shoulder Chapter (Online Version), Compression Garments, Cold Compression Therapy.

**MAXIMUS guideline:** Decision based on MTUS Shoulder Complaints 2004, Section(s): Initial Care. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder: Continuous flow cryotherapy; Cold compression therapy.

**Decision rationale:** The California MTUS are silent regarding cold compression therapy. Cryotherapy is recommended using standard cold packs. The Official Disability Guidelines do not recommend cold compression therapy in for patients undergoing shoulder surgeries. There is no evidence of improved clinical post-operative outcomes for patients using an active cooling and compression device over those using ice bags and elastic wrap after upper extremity surgery. The ODG support the limited use of continuous flow cryotherapy for 7 days following shoulder surgery. Guideline criteria have not been met. There is no compelling rationale presented to support the medical necessity of this request as an exception to guidelines. Therefore, this request is not medically necessary.