

<b>Case Number:</b>	CM15-0026810		
<b>Date Assigned:</b>	02/19/2015	<b>Date of Injury:</b>	09/27/2013
<b>Decision Date:</b>	03/31/2015	<b>UR Denial Date:</b>	01/14/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/12/2015

### 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:

The injured worker is a 39-year-old male who sustained an industrial injury on 09/27/13. The 12/8/14 treating physician report documented MR arthrogram findings of a partial thickness rotator cuff tear with supraspinatus and infraspinatus tendinitis, and a superior labral tear. The patient was scheduled for a right shoulder arthroscopy for labral tear and subacromial decompression. Physical exam documented full range of motion with some tenderness and negative apprehension sign. On 12/10/14, the patient underwent right shoulder arthroscopy with subacromial decompression. A 12/18/14 request for 30 days VascuTherm cold compression unit with compression wrap was submitted. The 1/14/15 utilization review non-certified the request for a cold compression unit. The ODG, Shoulder Chapter, Cold Compression Therapy was cited. The injured worker submitted an application for independent medical review of services requested.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Retrospective request for Post-operative 30 day rental of Vascultherm Cold & Compression device and pad purchase for unit, provided on date of service 12/10/14: 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), Shoulder Chapter, Cold compression therapy

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 203-204. Decision based on Non-MTUS Citation Shoulder: 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. There is no compelling reason in the records reviewed to support the medical necessity of a cold compression unit in the absence of demonstrated improved clinical efficacy. Therefore, this request is not medically necessary.