

<b>Case Number:</b>	CM15-0056113		
<b>Date Assigned:</b>	04/01/2015	<b>Date of Injury:</b>	12/13/2013
<b>Decision Date:</b>	05/11/2015	<b>UR Denial Date:</b>	03/13/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/24/2015

### 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: Minnesota, Florida  
 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 49-year-old male who sustained an industrial injury to his left shoulder and lower back on December 13, 2013. Diagnostic tests included magnetic resonance imaging (MRI) of the left shoulder on November 25, 2014 and a magnetic resonance imaging arthrogram on December 4, 2014. The injured worker was diagnosed with left shoulder labral rotator cuff tear, sprain lumbar area, myofascitis lower back and elbow forearm sprain. According to the primary treating physician's progress report on December 31, 2014, the injured worker continued to experience left shoulder burning pain, low back pain that radiated into the legs and left buttock. Examination of the left shoulder demonstrated decreased range of motion with global weakness. The lumbar spine had decreased range of motion with negative straight leg raise. Current medications were not listed. Treatment plan included left shoulder arthroscopy, which was certified by utilization review in March 2015. Associated surgical request for a post-op VascuTherm cold therapy (continuous-flow cryotherapy). was modified and is now appealed to an independent medical review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Post-Operative Vascultherm Cold Therapy, 3 times weekly for 3 weeks: 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.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG: Section: Shoulder, Topic: Continuous flow cryotherapy.

**Decision rationale:** The vascutherm device provides heat, cold, compression and/or DVT prophylaxis therapy. ODG guidelines recommend continuous flow cryotherapy as an option after shoulder surgery. The generally recommended postoperative use is for 7 days. Use beyond 7 days is not recommended. The request as stated is for 3 weeks and as such, the medical necessity of the request is not necessary.