

<b>Case Number:</b>	CM14-0118196		
<b>Date Assigned:</b>	08/06/2014	<b>Date of Injury:</b>	03/12/2013
<b>Decision Date:</b>	10/16/2014	<b>UR Denial Date:</b>	07/15/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/28/2014

### 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. The expert reviewer is Board Certified in Physical Medicine and Rehabilitation and is licensed to practice in California. 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/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:

This 44 year-old patient sustained an injury on 3/12/13 from a slip and fall while employed by [REDACTED]. Request(s) under consideration include x1 month Rental Cold Therapy/DVT Pneumatic Compression Unit. Diagnoses list s/p right shoulder rotator cuff tear; myofascial pain. MRI of right shoulder dated 4/5/13 showed moderate supraspinatus tendinosis and mild infraspinatus tendinosis with no rotator cuff tear seen, intact biceps long head; no labral degeneration; normal glenohumeral joint alignment with well-preserved articular surfaces. Medications list Norco, Prilosec, and Naprosyn. Report of 4/7/14 from the provider noted the patient with ongoing right shoulder pain exacerbated with activities. Exam showed right shoulder with limited range of flex/abd/ ER/ IR of 160/160/80 degrees and T10 behind the back; positive right anterior apprehension sign/ O'Brien's, Neer's, Hawkin's, Jobe/ impingement; tenderness of AC joint; positive anterior/ posterior acromioclavicular joint stress test on right; 4/5 diffuse motor weakness on abduction and external rotation. Plan was for right shoulder surgery. Report of 7/1/14 had no subjective or objective findings with submitted diagnosis of s/p right shoulder rotator cuff tear with request for cold therapy/ Deep vein thrombosis compression unit. There was notation that right shoulder arthroscopic acromioplasty, distal clavicle resection, labral repair versus debridement on 4/25/13 with scheduled surgery on 6/18/14. The request(s) for x1 month Rental Cold Therapy/DVT Pneumatic Compression Unit was non-certified on 7/15/14 citing guidelines criteria and lack of medical necessity.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**x1 month Rental Cold Therapy/DVT Pneumatic Compression Unit: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines - Continuous - flow Cryotherapy

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Cryotherapy/Cold & Heat Packs, pages 381-382; Vasopneumatic Cryotherapy (Knee, pages 292); Venous Thrombosis (knee), page 356-358.

**Decision rationale:** This 44 year-old patient sustained an injury on 3/12/13 from a slip and fall while employed by [REDACTED]. Request(s) under consideration include x1 month Rental Cold Therapy/DVT Pneumatic Compression Unit. Diagnoses list s/p right shoulder rotator cuff tear; myofascial pain. MRI of right shoulder dated 4/5/13 showed moderate supraspinatus tendinosis and mild infraspinatus tendinosis with no rotator cuff tear seen, intact biceps long head; no labral degeneration; normal glenohumeral joint alignment with well-preserved articular surfaces. Medications list Norco, Prilosec, and Naprosyn. Report of 4/7/14 from the provider noted the patient with ongoing right shoulder pain exacerbated with activities. Exam showed right shoulder with limited range of flex/abd/ ER/ IR of 160/160/80 degrees and T10 behind the back; positive right anterior apprehension sign/ O'Brien's, Neer's, Hawkin's, Jobe/ impingement; tenderness of AC joint; positive anterior/ posterior acromioclavicular joint stress test on right; 4/5 diffuse motor weakness on abduction and external rotation. Plan was for right shoulder surgery. Report of 7/1/14 had no subjective or objective findings with submitted diagnosis of s/p right shoulder rotator cuff tear with request for cold therapy/ Deep vein thrombosis compression unit. There was notation that right shoulder arthroscopic acromioplasty, distal clavicle resection, labral repair versus debridement on 4/25/13 with scheduled surgery on 6/18/14. The request(s) for x1 month Rental Cold Therapy/DVT Pneumatic Compression Unit was non-certified on 7/15/14. The Cold Therapy/DVT Pneumatic Compression unit delivers both cold/compression without need of ice directly to the cold wrap along with pneumatic compression via calf wraps aiding venous return. During the weeks following surgery, mobility is an issue, making the vasotherm unit necessary in preventing any risk of DVT developing while being immobile for multiple hours at a time. Per manufacturer, the device provides heat and cold compression therapy wrap for the patient's home for indication of pain, edema, and DVT prophylaxis for post-operative orthopedic patients. The patient has apparent right shoulder arthroscopic surgery; however, the provider does not identify specific risk factors for DVT prophylaxis. Per Guidelines, although DVT prophylaxis is recommended to prevent venothromboembolism (VTE) for patient undergoing knee or hip arthroplasty, it is silent on its use for shoulder arthroscopic surgery. Some identified risk factors identified include lower limb surgeries, use of hormone replacement therapy or oral contraceptives, and obesity, none of which apply in this case. Submitted reports have not demonstrated factors meeting criteria especially rehabilitation to include mobility and exercise are recommended post-shoulder surgical procedures as a functional restoration approach towards active recovery. MTUS Guidelines is silent on specific use of cold compression therapy, but does recommend standard cold pack for post exercise. ODG Guidelines specifically addresses the short-term benefit of cryotherapy post-surgery; however, limits the use for 7-day post-operative period as efficacy has not been proven after at which the patient was authorized for a modified 7 days post-op treatment. The x1 month Rental Cold Therapy/DVT Pneumatic Compression Unit is not medically necessary and appropriate.