

<b>Case Number:</b>	CM14-0183508		
<b>Date Assigned:</b>	11/10/2014	<b>Date of Injury:</b>	12/18/2013
<b>Decision Date:</b>	12/17/2014	<b>UR Denial Date:</b>	10/28/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/04/2014

### 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 Emergency Medicine 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:

The injured worker is a 52-year-old male who reported an injury on 12/18/2013. While working as a teacher, he was carrying a stack of CDs when a student came up behind him and scared him. His knee violently reacted and he lifted his right arm forcefully over his head and felt anterior shoulder pain. The diagnoses included adhesive capsulitis of the shoulder, affections of the shoulder region, and rotator cuff sprain/strain. Medications included naproxen and Motrin. An MRI of the right shoulder dated 02/05/2014 demonstrated normal appearing rotator cuff tendons and musculature with AC joint degenerative changes within further directed AC spurs with a type 2 acromial configuration. There was a normal long head of the biceps tendon and its anchor. There was a normal appearing glenohumeral joint. Past treatments included physical therapy, injections, and medication. The past surgeries included a right shoulder arthroscopic subacromial decompression, arthroscopic rotator cuff internal and posterior capsular release and an arthroscopic glenoid labral debridement dated 10/28/2014. The objective findings of the right shoulder dated 08/22/2014 revealed the examination of the right shoulder demonstrated 80% active and 90% passive range of motion with 30 degrees internal rotation contracture with pain at the end point, negative for AC and CS joint tenderness to palpation over aggravating maneuvers, negative Adson, negative Yergason's, and negative apprehension and negative upper cut tests. Rotator cuff testing was 5/5 except the supraspinatus isolation was 4+/5 with mild to moderate pain with isolation and loading. The plan included cold compression and a wrap of the right shoulder. The Request for Authorization dated 11/10/2014 was submitted with documentation.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Vascutherm for cold compression, 30 days rental for the right shoulder:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment, Chapter 9 Shoulder Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder, Cold Compression therapy

**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 decision for Vascutherm for cold compression, 30 days rental for the right shoulder is not medically necessary. The Official Disability Guidelines indicate that continuous flow cryotherapy is recommended as an option after surgery but not for nonsurgical treatment. Postoperative is generally up to 7 days including home use. Cryotherapy units have been proven to decrease pain, inflammation, swelling, and narcotic usage. The documentation indicates that the injured worker was approved for a continuous flow cryotherapy unit for 7 day use, which is recommended per the guidelines. The continuous flow cryotherapy is not recommended for 30 days. Therefore, the request is not medically necessary.

**Wrap for the right shoulder:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.