

<b>Case Number:</b>	CM15-0092574		
<b>Date Assigned:</b>	05/19/2015	<b>Date of Injury:</b>	11/05/2014
<b>Decision Date:</b>	06/19/2015	<b>UR Denial Date:</b>	05/11/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/13/2015

### 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: Connecticut, California, Virginia  
 Certification(s)/Specialty: Preventive Medicine, Occupational Medicine

### 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 61-year-old female, who sustained an industrial injury on 11/5/2014. She reported left shoulder injury after tripping and falling over a carpet. The injured worker was diagnosed as having status post left shoulder anterior dislocation, left shoulder rotator cuff tear, labral tear, bicep tear, and adhesive capsulitis. Treatment to date has included magnetic resonance imaging, physical therapy, x-rays, and 2 sessions of physical therapy. The request is for cold/heat compression wrap, and Vascutherm 30 day rental. A magnetic resonance imaging of the left upper extremity joint dated 11/25/2014, revealed supraspinatus diffuse tendinopathy with distal attenuation and suggestion of full thickness tear at the anterior insertion. On 12/8/2014, she is reported to have completed 2 physical therapy sessions. She had continued left shoulder pain, and is noted to have tenderness along the ulnar side. The treatment plan included: continuation of physical therapy. On 2/19/2015, she complained of left shoulder pain. Examination revealed mild tenderness at the AC joint, stiffness, and 50% of range of motion, pain and weakness with supraspinatus testing. The treatment plan included: surgery, and work restrictions.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Cold/heat compression wrap for the left shoulder:** 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, Cold compression therapy, Continuous-flow cryotherapy, Forearm, Wrist & Hand, Heat 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, Cold Compression therapy.

**Decision rationale:** The MTUS does not include guidance on the use of pneumatic compression devices for post-operative shoulders, and therefore the ODG guidelines provide the preferred mechanism for assessment of medical necessity in this case. With respect to cold compression therapy, the ODG does not recommend this treatment in the shoulder, as there are no published studies to provide evidence for efficacy, although it may be an option for other body parts. Because the guidelines clearly do not recommend use of pneumatic compression devices in post-operative shoulders, the request in this case cannot be considered medically necessary.

**Vascutherm 30-day rental for the left shoulder:** 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), Forearm, Wrist & Hand, Vasopneumatic devices.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) shoulder, continuous flow cryotherapy.

**Decision rationale:** Utilization review modified the request for cryotherapy (vascutherm) rental to 7 days rather than the requested 30 days. This is supported by the ODG guidelines, which state that continuous flow cold therapy is recommended as an option after surgery, but not for nonsurgical treatment. Based on the provided records and surgical intervention, it is the opinion of this reviewer that the modification to a 7-day rental per utilization review as a post-operative modality was appropriate, and therefore the initial request for a cold therapy unit for a period exceeding the recommendations of the ODG is not medically necessary.