

<b>Case Number:</b>	CM14-0002437		
<b>Date Assigned:</b>	06/13/2014	<b>Date of Injury:</b>	05/21/2011
<b>Decision Date:</b>	07/28/2014	<b>UR Denial Date:</b>	12/20/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/07/2014

### 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 Orthopaedic Surgery 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 71-year-old female cook sustained an industrial injury on 5/21/11, relative to repetitive job activities. The patient underwent left shoulder arthroscopic surgeries on 6/28/11 and 7/10/13. The 2/7/13 right shoulder MRI impression documented infraspinatus calcific tendinitis with 4 mm calcium deposit in distal fibers, and superimposed moderate rotator cuff tendinosis. There was chronic degeneration, blunting and tearing of the superior labrum. There was moderate acromioclavicular joint arthrosis and moderate biceps tendinosis. The 12/12/13 treating physician report cited improved left shoulder pain and range of motion status post arthroscopy. The patient complained of intermittent right shoulder pain. Right shoulder range of motion documented forward flexion 150 degrees, extension 30 degrees, abduction 150 degrees, internal rotation 60 degrees, and external rotation 60 degrees. Bilateral supraspinatus strength was 4/5. Right shoulder orthopedic testing documented positive crossover, Hawkin's, O'Brien's, Speed's and supraspinatus tests. The patient was scheduled for right shoulder arthroscopy with subacromial decompression, distal clavicle resection, biceps tenodesis, and biceps tenotomy. The 12/20/13 utilization review denied the request for purchase of the Polar Care kit, but certified a separate request for 7-day rental of the Polar Care kit. The request for CPM (Continuous Passive Motion) kit for 21 days was denied as there was no evidence of adhesive capsulitis to support the medical necessity consistent with guidelines.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Polar Care kit for purchase:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 561-563. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder, 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) Shoulder, Continuous flow cryotherapy.

**Decision rationale:** The California MTUS are silent regarding cold therapy devices. The Official Disability Guidelines recommend continuous flow cryotherapy as an option after shoulder surgery. Postoperative use generally may be up to 7 days, including home use. In the postoperative setting, continuous-flow cryotherapy units have been proven to decrease pain, inflammation, swelling, and narcotic usage. This request is for purchase of a Polar Care kit is not consistent with guidelines. The 12/20/13 utilization review certified a Polar Care unit for 7-day rental. There is no compelling reason in the records reviewed to support the medical necessity of a cold device beyond the 7-day rental recommended by guidelines and previously certified. Therefore, this request for Polar Care kit for purchase is not medically necessary.

**Continuous Passive Motion (CPM) kit for 21 days .:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Shoulder (updated 06/12/13), Continuous passive motion (CPM).

**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 passive motion (CPM).

**Decision rationale:** The California MTUS does not provide recommendations for this device in chronic shoulder conditions. The Official Disability Guidelines state that continuous passive motion (CPM) is not recommended for shoulder rotator cuff problems or after shoulder surgery, except in cases of adhesive capsulitis. Guideline criteria have not been met. There is no current evidence that this patient has adhesive capsulitis. Therefore, this request for continuous passive motion (CPM) kit for 21 days is not medically necessary.