

<b>Case Number:</b>	CM14-0073653		
<b>Date Assigned:</b>	07/16/2014	<b>Date of Injury:</b>	10/10/2012
<b>Decision Date:</b>	08/14/2014	<b>UR Denial Date:</b>	05/14/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/20/2014

### 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:

According to the records made available for review, this is a 37-year-old male with a 10/10/12 date of injury, and subacromial decompression and release of adhesion with manipulation under anesthesia on 7/11/13. At the time (5/14/14) of the Decision for Polar pack, there is documentation of subjective (right shoulder pain) and objective (right shoulder posterior atrophy, tenderness over the AC joint, crepitus in the subacromial space, positive impingement sign, and decreased right muscle strength) findings, current diagnoses (right shoulder recurrent supraspinatus tendon tearing and right shoulder impingement), and treatment to date (right shoulder surgery (most recent on 7/11/13)). Medical reports identify a request for right shoulder revision acromioplasty and rotator cuff repair.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Polar pack:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines Treatment in Worker's Comp 18th edition, 2013: 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, Polar care (cold therapy unit).

**Decision rationale:** California Medical Treatment Utilization Schedule (MTUS) does not address this issue. Official Disability Guidelines (ODG) identifies that continuous-flow cryotherapy is recommended as an option after surgery for up to 7 days, including home use. Within the medical information available for review, there is documentation of diagnoses of right shoulder recurrent supraspinatus tendon tearing and right shoulder impingement. However, despite documentation of a plan indicating a request for right shoulder revision acromioplasty and rotator cuff repair, there is no documentation of a pending surgery that has been certified/authorized. Therefore, based on guidelines and a review of the evidence, the request for Polar pack is not medically necessary.