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| Case Number: | CM14-0092201 | | |
| Date Assigned: | 07/25/2014 | Date of Injury: | 03/27/2013 |
| Decision Date: | 09/08/2014 | UR Denial Date: | 06/12/2014 |
| Priority: | Standard | Application Received: | 06/18/2014 |

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 & Rehabilitation, has a subspecialty in Pain Management and is licensed to practice in Texas and Oklahoma. 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 67-year-old male who reported an injury on 03/27/2013. The mechanism of injury was not provided. On 03/04/2014, the injured worker presented with chronic left shoulder and left medial elbow pain. The diagnosis was pain in the joint/shoulder status post left shoulder arthroscopy with RCR decompression and biceps tenotomy. Upon examination, the injured worker had complaints of numbness and weakness, but denied balance problems, poor concentration, memory loss, seizures, or tremors. The MRI arthrogram of the left shoulder performed on 12/18/2013 revealed mild to moderate tendinosis or postsurgical appearance of rotator cuff with mild fraying of the articular surface fibers of the distal supraspinatus and infraspinatus tendons and mild thinning of the distal subscapularis tendon. The provider recommended polar care but, the provider's rationale is not provided. The Request for Authorization Form was not included in the medical documents for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Polar care, unknown quantity or duration.: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG: Shoulder Chapter: 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), Knee & Leg, Cryotherapy.

Decision rationale: The request for Polar Care, unknown quantity or duration is not medically necessary. The Official Disability Guidelines recommend a polar care unit as an option after surgery for up to 7 days, including home use. The request for a polar care unit exceeds the recommendations of the guidelines. It is unclear if the request is for the purchase or rental of the unit and the medical documents provided do not indicate a medical need for the cryotherapy unit that would fall within the guideline limitation; such as surgery. As such, the request is not medically necessary.