

<b>Case Number:</b>	CM15-0002576		
<b>Date Assigned:</b>	01/13/2015	<b>Date of Injury:</b>	06/26/2008
<b>Decision Date:</b>	03/20/2015	<b>UR Denial Date:</b>	12/31/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/06/2015

### 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: California

Certification(s)/Specialty: Orthopedic Surgery, Sports 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 40-year-old male who reported an injury on 06/23/2008, due to cumulative trauma while performing normal job duties. The injured worker reportedly sustained an injury to his left shoulder. The injured worker's treatment history included physical therapy, injections, and multiple surgical interventions with post surgical therapy. The injured worker was evaluated on 11/25/2014. It was documented that the injured worker had persistent left arm symptoms. Physical examination findings included an inability to lift his arm above 90 degrees against gravity with significant pain and weakness and painful mechanical symptoms of the left shoulder. The injured worker's diagnoses included left arm pain of the acromioclavicular joint, left superior glenoid labrum lesion and left biceps tendon rupture. The injured worker's treatment plan included surgical intervention. A Request for Authorization for surgical intervention followed by post surgical therapy and Polar care unit and a sling was submitted on 12/15/2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Polar care/cold therapy post-operatively:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation 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 Chapter, Continuous Flow Cryotherapy

**Decision rationale:** The requested Polar care cold therapy unit postoperatively is not medically necessary or appropriate. California Medical Treatment Utilization Schedule does not address this request. Official Disability Guidelines recommend the use of a cold therapy unit postsurgically to assist with pain and inflammation for up to 7 days. The request, as it is submitted, does not clearly identify a parameter for treatment duration. Although, the use of a cold therapy unit may be appropriate in this clinical situation, in the absence of a duration of treatment the appropriateness of the request itself cannot be determined. As such, the requested Polar care cold therapy unit postoperatively is not medically necessary or appropriate.