

<b>Case Number:</b>	CM15-0081147		
<b>Date Assigned:</b>	05/01/2015	<b>Date of Injury:</b>	12/30/2010
<b>Decision Date:</b>	06/12/2015	<b>UR Denial Date:</b>	04/20/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/28/2015

### 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, Indiana, Oregon  
 Certification(s)/Specialty: Orthopedic Surgery

### 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 56 year old female with an industrial injury dated 12/30/2010. The injured worker's diagnoses include carpal tunnel syndrome, trigger finger and sprain/strain unspecified site of the shoulder and upper arm. Treatment consisted of Magnetic Resonance Imaging (MRI) of the left shoulder, prescribed medications, and periodic follow up visits. In a progress note dated 4/20/2015, the injured worker reported left shoulder pain radiating down the left upper arm and left wrist pain. Objective findings revealed subacromial and bicipital groove tenderness to palpitation and pain elicited with left shoulder range of motion. The treating physician reported that the MRI of the left shoulder from 9/9/2014 revealed a rotator cuff tear, subscapularis tear and biceps tendon subluxation. The treatment plan consisted of left shoulder surgery with associated surgical services. The treating physician prescribed services for rental of polar care unit for 14 days now under review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Rental of polar care unit for 14 days:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines.

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

**Decision rationale:** CA MTUS/ACOEM is silent on the issue of shoulder cryotherapy. According to ODG Shoulder Chapter, Continuous flow cryotherapy, it is recommended immediately postoperatively for upwards of 7 days. In this case the request is for 14 day rental postoperatively for the cryotherapy unit. Therefore the determination is not medically necessary.