

<b>Case Number:</b>	CM14-0113130		
<b>Date Assigned:</b>	09/16/2014	<b>Date of Injury:</b>	05/10/2010
<b>Decision Date:</b>	10/15/2014	<b>UR Denial Date:</b>	06/24/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/18/2014

### 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 Anesthesiology, has a subspecialty in Pain Medicine and is licensed to practice in Texas and Florida. 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 patient is a 61 year old female who was injured on 5/10/2010. The diagnoses are right shoulder pain, thoracic and lumbar spine pain. The past surgery history is significant for left hip and right knee replacements. The MRI of the right shoulder was significant for full thickness tear of the supraspinatus tendon and acromio-clavicular joint arthrosis. The patient had completed PT and home exercise program. On 6/10/2014, [REDACTED] noted subjective complaints of reduced physical activities due to severe right shoulder pain. There was decreased range of motion of the shoulder. The medications are Norco and ibuprofen for pain and Tizanidine for muscle spasm. A Utilization Review determination was rendered on 6/24/2014 recommending modified certification for post-operative Polar care for 7 days.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Polar Care:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines; Work Loss Data Institute - Section: Shoulder (Acute and Chronic) updated 05/25/2014

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

**Decision rationale:** The CA MTUS did not address the use of continuous flow cryotherapy for post operation management following shoulder surgery. The ODG guidelines recommend that a 7 days cyrotherapy treatment can be beneficial during the post-operative period following musculoskeletal surgery. The records indicate that the patient will be undergoing rotator cuff surgery. The criterion was met for 7 days of post-operative use of the Polar Care unit.