

Case Number:	CM14-0216366		
Date Assigned:	01/27/2015	Date of Injury:	10/29/2008
Decision Date:	03/06/2015	UR Denial Date:	11/25/2014
Priority:	Standard	Application Received:	12/24/2014

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. 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: Minnesota, Florida
 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 58-year-old male with date of injury of 10/29/2008. He complained of left shoulder pain. An MRI scan of the left shoulder dated 7/12/2013 revealed rotator cuff tendinosis, slight articular surface fraying of the distal supraspinatus and infraspinatus tendons, no discrete tear or gap present, degenerative changes of the labrum with fraying inferiorly, small cystic changes around the labrum posteriorly from adjacent labral tear, acromioclavicular joint arthritis, synovitis, and glenohumeral osteoarthritis. The diagnosis was impingement syndrome. A request for arthroscopy of the left shoulder, repair of labrum, evaluation of biceps and evaluation of the rotator cuff was certified by utilization review. The disputed issue pertains to a request for DME Polar Care 21 day rental which was modified by utilization review to a 7 day rental as medically necessary and appropriate. This is now appealed to an independent medical review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Post-operative Polar Care x 21 Day Rental for the Left Shoulder: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder, Continuous flow cryotherapy

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS.
Decision based on Non-MTUS Citation Section: Shoulder, Topic: Continuous Flow Cryotherapy

Decision rationale: California MTUS guidelines do not address this issue. ODG guidelines are therefore used. Continuous-flow cryotherapy is recommended as an option after surgery, but not for nonsurgical treatment. Postoperative use generally may be up to 7 days, including home use. These units have been proven to decrease pain, inflammation, swelling, and need for narcotics postoperatively. The request as stated is for a 21-day rental which is not supported by guidelines and as such, the medical necessity of the request is not substantiated.