

Case Number:	CM14-0183561		
Date Assigned:	11/12/2014	Date of Injury:	10/01/2009
Decision Date:	12/15/2014	UR Denial Date:	10/23/2014
Priority:	Standard	Application Received:	11/04/2014

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 Orthopedic Surgery, and is licensed to practice in California. 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:

According to the records made available for review, this is a 70-year-old female with a 10/1/09 date of injury. At the time (9/26/14) of request for authorization for Associated surgical service: Cold therapy unit & pad, Associated surgical service: Ambien 10mg #12, and Associated surgical service: Home health care visits two times a day for six week (2/day x 6 weeks), there is documentation of subjective (sleep difficulties and bilateral shoulder pain radiating to the shoulder blades, arms, and forearms) and objective (restricted range of motion of the left shoulder, positive impingement maneuver, Neer's, and Hawkins' tests; and positive cubital Tinel and wrist Tinel signs bilaterally) findings, current diagnoses (bilateral shoulder impingement with partial thickness rotator cuff tears), and treatment to date (physical therapy, TENS unit, shoulder subacromial injections, acupuncture, and medications (including ongoing treatment with Tramadol)). Medical reports identify a pending left shoulder arthroscopic subacromial decompression and Mumford, possible rotator cuff tear repair, and possible biceps tenodesis surgery that has been authorized/certified. Regarding Cold therapy unit & pad, there is no documentation that the requested cold therapy will be used postoperatively for up to 7 days. Regarding Ambien 10mg #12, there is no documentation of Insomnia. Regarding Home health care visits two times a day for six week (2/day x 6 weeks), there is no documentation that the patient requires recommended medical treatment (where homemaker services like shopping, cleaning, and laundry, and personal care given by home health aides like bathing, dressing, and using the bathroom is not the only care needed) and the patient is home-bound on a part-time or intermittent basis.

IMR ISSUES, DECISIONS AND RATIONALES

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

Associated surgical service: Cold therapy unit & pad: 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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder, Polar care (cold therapy unit)

Decision rationale: MTUS does not address this issue. ODG states that continuous-flow cryotherapy is recommended postoperatively for up to 7 days, including home use. Within the medical information available for review, there is documentation of a diagnosis of bilateral shoulder impingement with partial thickness rotator cuff tears. In addition, there is documentation of a pending left shoulder arthroscopic subacromial decompression and Mumford, possible rotator cuff tear repair, and possible biceps tenodesis surgery that has been authorized/certified. However, there is no documentation that the requested cold therapy will be used postoperatively for up to 7 days. Therefore, based on guidelines and a review of the evidence, the request for associated surgical service, Cold therapy unit & pad is not medically necessary.

Associated surgical service: Ambien 10mg #12: 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), Pain

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

Decision rationale: MTUS does not address this issue. ODG identifies Ambien (zolpidem) as a prescription short-acting nonbenzodiazepine hypnotic, which is approved for the short-term (usually two to six weeks) treatment of insomnia. Within the medical information available for review, there is documentation of a diagnosis of bilateral shoulder impingement with partial thickness rotator cuff tears. However, despite documentation of sleep difficulties, there is no (clear) documentation of Insomnia. Therefore, based on guidelines and a review of the evidence, the request for associated surgical service, Ambien 10mg #12 is not medically necessary.

Associated surgical service: Home health care visits two times a day for six week (2/day x 6 weeks): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Home health services

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Home health services Page(s): 51.

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines identifies documentation that the patient requires recommended medical treatment (where homemaker services like shopping, cleaning, and laundry, and personal care given by home health aides like bathing, dressing, and using the bathroom is not the only care needed) and the patient is home-bound on a part-time or intermittent basis, as criteria necessary to support the medical necessity of home health services. In addition, MTUS Chronic Pain Medical Treatment Guidelines identifies documentation of no more than 35 hours per week. Within the medical information available for review, there is documentation of a diagnosis of bilateral shoulder impingement with partial thickness rotator cuff tears. However, there is no documentation that the patient requires recommended medical treatment (where homemaker services like shopping, cleaning, and laundry, and personal care given by home health aides like bathing, dressing, and using the bathroom is not the only care needed) and the patient is home-bound on a part-time or intermittent basis. Therefore, based on guidelines and a review of the evidence, the request associated surgical service, Home health care visits two times a day for six week (2/day x 6 weeks) is not medically necessary.