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| Case Number: | CM13-0007719 | | |
| Date Assigned: | 12/04/2013 | Date of Injury: | 05/10/2012 |
| Decision Date: | 01/17/2014 | UR Denial Date: | 07/17/2013 |
| Priority: | Standard | Application Received: | 08/07/2013 |

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Anesthesiology, has a subspecialty in Pain Medicine and is licensed to practice in California and Texas. 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 physician 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 44-year-old male who reported an injury on 05/10/2012. The patient is noted to have diagnoses to include right shoulder rotator cuff tear, low back pain with multi-level disc osteophytes, and cervical spine pain with disc protrusion. The patient's subjective complaints in the most recent office note were illegible, and there were no objective findings stated.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lumbar-Sacral Orthosis L0631: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 114.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300.

Decision rationale: According to the ACOEM Guidelines, lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptom relief. As the request is for lumbar-sacral orthosis for the patient's chronic pain, it is not supported by the guidelines. Therefore, the lumbar-sacral orthosis is not medically necessary.

Solar Care FIR Heating System E0211: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines
Page(s): 114.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS.
Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back, Heat
Therapy.

Decision rationale: The Official Disability Guidelines state that heat therapy is recommended as an option for treating low back pain, as a number of studies show continuous low-level heat wrap therapy to be effective. The patient has been shown to have low back pain; however, it is not stated in the documentation as to the reason the patient requires the Solar Care FIR Heating System, rather than a recommended wrap, for heat therapy. Without this documentation, the request is not supported. Therefore, the Solar Care FIR Heating System is not medically necessary and appropriate.