

Case Number:	CM13-0038136		
Date Assigned:	06/06/2014	Date of Injury:	11/13/2010
Decision Date:	08/07/2014	UR Denial Date:	09/17/2013
Priority:	Standard	Application Received:	09/27/2013

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 Occupational Medicine 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:

The patient is a 53-year-old female who has submitted a claim for left rotator cuff tear, right carpal tunnel syndrome status post carpal tunnel release, status post right ankle peroneal bevis repair, associated with an industrial injury date of November 13, 2010. Medical records from 2013 through 2014 were reviewed, which showed that the patient complained of right hand, right ankle, and left shoulder pain. On physical examination of the left shoulder, there was tenderness of the acromioclavicular joint. Impingement, Neer, and Hawkins signs were positive. No instability was noted. No motor deficits were reported. Range of motion was within normal limits. Right hand examination revealed full range of motion. Phalen and Tinel signs were negative. No sensory deficits of the upper extremities were noted. Deep tendon reflexes were brisk and equal. Grip strength was decreased on the right hand. Right foot and ankle examination revealed full range of motion. There was tenderness about the posterior aspect of the tibia. No sensorimotor deficits were noted. Treatment to date has included medications, right carpal tunnel release, right repair of peroneal brevis tendon, and physical therapy. Utilization review from September 17, 2013 denied the request for a Solar Care FIR Heating System. The rationale for determination was not included in the records for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

SOLAR CARE FIR HEATING SYSTEM: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

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, INFRARED THERAPY.

Decision rationale: ODG states that infrared (IR) therapy is not recommended over other heat therapies. Where deep heating is desirable, providers may consider a limited trial of IR therapy for treatment of acute low back pain but only as an adjunct to a program of evidence-based conservative care. In this case, the Solar Care FIR Heating System was requested to empower the patient to become independent and to help her take a role in the management of her symptoms. However, there was no discussion regarding why infrared therapy was necessary, when other forms of heat therapies are available. There was also no discussion regarding the indication for deep heating. Furthermore, the present written request failed to specify whether this is a purchase or a trial request. Therefore, the request is not medically necessary.