

Case Number:	CM13-0066662		
Date Assigned:	01/03/2014	Date of Injury:	12/21/2010
Decision Date:	04/21/2014	UR Denial Date:	11/26/2013
Priority:	Standard	Application Received:	12/16/2013

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 Physical Medicine & Rehabilitation, and is licensed to practice in Illinois. 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 57-year-old male who sustained an unspecified injury on 12/21/2010. The patient was evaluated on 09/25/2013 for continued complaints of low back pain and right knee pain. The documentation submitted for review indicated the patient had tenderness to palpation over the right bilateral paraspinal musculature, right more than left. The patient had a positive Kemp's and was noted to have difficulty with toe and heel walking due to pain and weakness. The patient additionally was noted to have tenderness to palpation over the right anteromedial and lateral joint line of the knee. The patient's motor strength was noted to be 4/5. The documentation submitted for review indicated the patient underwent an MRI on 06/24/2013 which indicated the patient had an L2-3 three mm disc protrusion, L3-4 two mm disc protrusion, L4-5 three mm disc protrusion, and L5-S1 two mm disc protrusion. The documentation further indicated the patient underwent an EMG/NCV on 06/24/2013 which had normal findings. The treatment plan indicated the patient was to continue medication, request for a home exercise kit and a heat unit to help the patient's circulation and muscle spasms.

IMR ISSUES, DECISIONS AND RATIONALES

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

SOLAR-CARE HEATING SYSTEM (USE DAILY AS NEEDED, 6-8 HRS/DAY, PURCHASE): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 339.

Decision rationale: The documentation submitted for review indicated a heating system as part of a treatment plan for the patient. The patient was seen for low back pain and right knee pain. The documentation submitted for review did not indicate where the heat unit would be administered. The ACOEM guidelines do not recommend the use of low level laser therapy for knee disorders. The Solar Care unit is a low level laser therapy unit. Therefore, the use of the unit is not supported. Furthermore, the guidelines recommend any durable medical equipment be used on a rental basis. The documentation submitted for review did not indicate the need for purchase over rental. Therefore, the purchase of the unit is not supported. Given the information submitted for review, the request for Solar Care heating system (used daily as needed, 6 to 8 hours a day, purchase) is non-certified.

OOPTIMUM REHAB KIT: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Section Exercise Page(s): 46-47.

Decision rationale: The documentation submitted for review indicated the need for a home exercise kit so the patient could perform activities at home which he would learn from a work hardening program. The documentation submitted for review did not include evidence that patient was eligible for a work hardening program. The California MTUS Guidelines recommend the use of exercise as part of a treatment program. However, the guidelines state there is no sufficient evidence to support the recommendation of any particular exercise regimen over any other exercise regimen. Therefore, the need for exercise equipment is unclear. Furthermore, the documentation submitted for review did not indicate what would be included in the exercise kit. Given the information submitted for review, the request for optimum rehab kit is non-certified.