

<b>Case Number:</b>	CM14-0102198		
<b>Date Assigned:</b>	07/30/2014	<b>Date of Injury:</b>	09/06/2006
<b>Decision Date:</b>	09/19/2014	<b>UR Denial Date:</b>	06/24/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/02/2014

### 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 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 38 year old female who sustained a CT injury to her right shoulder, elbow, and wrist on 09/06/2006. Progress report dated 05/12/2014 states the patient complained of neck pain radiating down the right upper extremity and the pain is aggravated by activity. She rated her pain with medications a 8/10 and without medications 10/10. Her activities of daily living are limited by the pain. Objective findings on exam revealed tenderness at the right rotator cuff, right anterior shoulder and mild swelling is noted in the right hand. Range of motion of the right shoulder, right elbow was decreased due to pain and right wrist due to the pain. Diagnoses are complex regional pain syndrome, right upper extremity; chronic pain. The patient was given Nucynta ER for her moderate to severe pain and neuropathic pain, Prilosec, Ambien, Lidoderm, and Norco. Prior utilization review dated 06/24/2014 states the request for Solar-Care FIR Heating System purchase; use 6-8 hours/day is denied as there is a lack of evidence to support the request.

### 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 purchase; use 6-8 hours/day:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) (web): Heat packs.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints, Chapter 9 Shoulder Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Heat therapy, Infrared therapy.

**Decision rationale:** This is a request for a Solar Care FIR heating system for a 38-year-old female with chronic pain. However, according to ODG and MTUS guidelines infrared therapy is not recommended over other standard heat therapies due to lack of proven superior efficacy. Therefore, Solar-Care FIR Heating System purchase; use 6-8 hours/day is not medically necessary and appropriate.