

<b>Case Number:</b>	CM14-0115068		
<b>Date Assigned:</b>	08/04/2014	<b>Date of Injury:</b>	08/13/2012
<b>Decision Date:</b>	09/16/2014	<b>UR Denial Date:</b>	07/08/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/22/2014

### 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 Physical Medicine & Rehabilitation and is licensed to practice in Texas and Oklahoma. 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 injured worker is a 44-year-old male who reported an injury 08/13/2012. The mechanism of injury was not provided within the medical records. The clinical note dated 05/05/2014 is handwritten and hard to decipher. The diagnoses included right shoulder rule out degeneration of superior labrum and partial detachment, right wrist rule out I.D. The injured worker reported right shoulder pain rated 3/10, and difficulty with lifting the arm. The injured worker had an MRI of the right shoulder. The unofficial MRI revealed degeneration of superior labrum, partial detachment of articular margin. He has had 24 sessions of physical therapy and 3 cortisone injections with mild relief. On physical examination he guarded the right shoulder. The injured worker had tenderness to the AC joint, bicep tendon groove and super deltoid of the right shoulder. Motor testing of the right shoulder revealed 4+ on the right with weakness. His shoulder range of motion was flexion of 120 with pain, extension of 35 with pain. The injured worker's prior treatments included diagnostic imaging, physical therapy and medication management. His medications included ibuprofen. The provider submitted a request for a Solar Care infrared heating system. A Request for Authorization was not submitted for review to include the date the treatment was requested.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**1 Purchase of Solar Care Far Infrared Heating System/Portable Far Infrared Head Pad for the Right Shoulder and Right Wrist: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) - Treatment for Worker's Compensation, Online Edition; Chapter: Forearm, Wrist, & Hand (Heat therapy).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Official Disability Guidelines (ODG), Low Back, Infrared therapy, (IR).

**Decision rationale:** The request for 1 Purchase of Solar Care Far Infrared Heating System/Portable Far Infrared Head Pad for the Right Shoulder and Right Wrist is non-certified. The Official Disability Guidelines do not recommend Infrared therapy over other heat therapies. Where deep heating is desirable, providers may consider a limited trial of IR therapy for treatment of acute LBP, but only if used as an adjunct to a program of evidence-based conservative care (exercise). The provider did not indicate a rationale for the request. In addition, the guidelines do not recommend infrared over other heat therapies. Furthermore, if infrared is used, the guidelines recommend it in adjunct to a program of evidence based conservative care. It was not indicated that the injured worker was still participating in physical therapy. In addition, there was lack of documentation of the injured worker participating in a trial with documentation of the efficacy of the unit and information pertaining to the usage of the unit. Therefore, the purchase of 1 Solar Care Far Infrared Heating System/Portable Far Infrared Head Pad for the Right Shoulder and Right Wrist is not medically necessary.