

Case Number:	CM14-0174780		
Date Assigned:	10/27/2014	Date of Injury:	07/19/2013
Decision Date:	12/03/2014	UR Denial Date:	10/07/2014
Priority:	Standard	Application Received:	10/21/2014

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 and Rehabilitation, has a subspecialty in Pain 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:

This is a patient with a date of injury of July 19, 2013. A utilization review determination dated October 7, 2014 recommends non-certification of "solar care infrared heating unit." Non-certification was recommended since ODG states that infrared is not recommended over other heat therapies in the back. A request dated September 23, 2014 recommends "solar care heating system purchase." A progress report dated September 23, 2014 identifies subjective complaints of (illegible) a follow-up. Patient has pain in bilateral feet at all times. Patient works (illegible) standing." Objective examination findings identify calcaneal pain with palpation, shoulder with inadequate range of motion and positive Hawkins test, and back with decreased flexion and extension. Diagnoses included bilateral shoulder pain, small plantar spur calcaneal, L3-L4 disc space narrowing, and lumbar sprain. The treatment plan recommends an interferential unit, solar care shoulders, lumbar spine, and but, rehab kit, podiatry consult, MRI, medication, continue therapy, and x-rays.

IMR ISSUES, DECISIONS AND RATIONALES

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

Purchase of solar care infrared heating unit: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)-TWC Ankle & Foot Procedure Summary.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300, Chronic Pain Treatment Guidelines Page(s): 57. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Chronic Pain Chapter, Low Level Laser Therapy, Low Back Chapter, Cold/Heat Packs.

Decision rationale: Regarding the use of infrared devices, Chronic Pain Medical Treatment guidelines state that low level laser therapy such as red beam or near infrared therapy is not recommended. Guidelines indicate that there is insufficient evidence to support the use of this modality in the treatment of chronic pain. Regarding heat therapy, Occupational Medicine Practice Guidelines state that various modalities such as heating have insufficient testing to determine their effectiveness, but they may have some value in the short term if used in conjunction with the program of functional restoration. ODG states that heat/cold packs are recommended as an option for acute pain. Within the documentation available for review, and there is no indication that the patient has acute pain. Additionally, it is unclear what program of functional restoration the patient is currently participating in which would be used alongside the currently requested heat therapy. Additionally, no peer-reviewed scientific literature has been provided which would overrule the guidelines recommendations which do not support infrared treatment. As such, the currently requested infrared device is not medically necessary.