

<b>Case Number:</b>	CM14-0032624		
<b>Date Assigned:</b>	06/20/2014	<b>Date of Injury:</b>	11/09/2011
<b>Decision Date:</b>	08/12/2014	<b>UR Denial Date:</b>	02/17/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/14/2014

### 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 Anesthesiology, 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:

The patient is a 50 year old male who reported an injury to his left knee. No information was submitted regarding initial injury. A clinical note dated 02/11/14 indicated the patient complaining of moderate levels of pain at the left knee and severe low back pain and neck pain. The patient utilized tramadol for ongoing pain relief. Upon exam, sensation was decreased at the left lower extremity in L4 through S1 distributions. The patient demonstrated 0-90 degrees of range of motion at the left knee and 0-110 degrees at the right knee. Tenderness was identified at the lateral joint line and patellofemoral region. The patient had a positive McMurray test indicating medial meniscus tear. Strength was 4/5 throughout quadriceps, hamstrings, gastrocnemius and extensor hallucis longus on the left. Functional clinical note dated 02/11/13 indicated the patient continue showing significant functional deficits. The patient was identified by functional capacity evaluation as having significant limitations in the lumbar spine and left knee. Moderate weakness was identified in the musculature throughout the trunk. Utilization review dated 02/17/14 resulted in denials for the use of solar care heating system and X-Force stimulation unit as insufficient information had been submitted regarding the medical necessity for these treatment modalities.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Solar Care Heating System purchase:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Page(s): 299. Decision based on Non-MTUS Citation Official Disability Guidelines: Lumbar Chapter.

**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 Chapter, Infrared therapy (IR).

**Decision rationale:** The request for a solar care heating system purchase is not medically necessary. The clinical documentation indicates the patient complaining of left knee and low back pain. The use of heat therapy is indicated for ongoing complaints of low back pain. However, the use of solar/infrared therapy is not recommended over other heat therapies. No information was submitted regarding inadequate response to additional heat therapy. Therefore, the use of solar therapy is not fully indicated for this patient at this time.

**X-Force Stimulator Unit Purchase with three (3) months supply and conductive garment (times two (2)):** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines TENS (transcutaneous electrical nerve stimulation).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines TRANSCUTANEOUS ELECTROTHERAPY Page(s): 113-7.

**Decision rationale:** The use of a stimulation unit is indicated provided that the patient meets specific criteria, including positive response including objective functional improvement with through a one month trial. No information was submitted regarding previous trial of X-Force stimulation unit. The request for X-Force stimulator unit purchase with three month supply and conductive garments times two is not medically necessary.