

<b>Case Number:</b>	CM14-0043617		
<b>Date Assigned:</b>	07/02/2014	<b>Date of Injury:</b>	03/24/2012
<b>Decision Date:</b>	08/26/2014	<b>UR Denial Date:</b>	04/03/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/10/2014

### 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 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 51-year-old female who reported injury on 03/24/2012. The mechanism of injury was not provided. The diagnosis included ulnar nerve lesion. Prior treatments included acupuncture treatments. Medications included Tylenol, Lodine, Etodolac ER, Polar Frost 150 ML and Acetaminophen 500 mg capsules. Documentation of 06/26/2014 revealed the injured worker had numbness and tingling to the left greater than right 4th and 5th digits. The office note was handwritten and difficult to read. The diagnosis included right cubital tunnel syndrome. The treatment plan included a home exercise program and an interferential unit.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**1 infra lamp:** Upheld

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

**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 Official Disability Guidelines indicate that infrared therapy is not recommended over other heat therapies. The clinical documentation submitted for review failed

to provide documentation of a DWC form, RFA or PR2 specifically requesting an infrared lamp. The request as submitted failed to indicate whether the request for purchase or rental and, if for rental the request as submitted failed to include the duration of use. Given the above, the request for 1 infrared lamp is not medically necessary.

**1 medical supply/ kinesiotape:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee & Leg Chapter, Kinesio tape (KT).

**Decision rationale:** The Official Disability Guidelines indicate that Kinesio Tape is not recommended. There was lack of documentation that exceptional factors to warrant non-adherence to guideline recommendations. There was no legible documentation requesting the Kinesio Tape. No PR-2 or DWC form RFA was submitted requesting the medical supply. Given the above, the request for 1 medical supply Kinesio Tape is not medically necessary.