

<b>Case Number:</b>	CM14-0189317		
<b>Date Assigned:</b>	11/21/2014	<b>Date of Injury:</b>	09/13/2012
<b>Decision Date:</b>	01/08/2015	<b>UR Denial Date:</b>	11/03/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/13/2014

### 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 General Preventive Medicine and is licensed to practice in Indiana. 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 employee is a 48 year old female with date of injury of 9/13/2012. A review of the medical records indicate that the patient is undergoing treatment for severe right upper extremity complex regional pain syndrome with right arm ankylosis. Subjective complaints include continued neck pain rated at 9/10 along with right upper extremity pain; unable to move her right hand. Objective findings include right upper extremity is discolored with severe edema, allodynia, and hyperalgesia; ankylosis of the shoulder, elbow, and wrist; tenderness and limited motion of the cervical spine. Treatment has included acupuncture, hydrocodone, and norhydrocodone. The utilization review dated 11/13/2014 non-certified infrared therapy.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Infrared, 2-3 times a week, unspecified body part:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability 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, Infrared Therapy

**Decision rationale:** MTUS is silent on this topic. However, ODG states the following: "Not recommended 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 IR therapy unit used in this trial was demonstrated to be effective in reducing chronic low back pain, and no adverse effects were observed; the IR group experienced a 50% pain reduction over 7 weeks, compared with 15% in the sham group." There is no documentation of a home exercise program being used. Furthermore, the date of injury was 9/13/2012 and so it is beyond the acute phase of pain and there is no detail on what the infrared therapy would be for, including the body part. Therefore, the request is not medically necessary.