

Case Number:	CM14-0196443		
Date Assigned:	12/03/2014	Date of Injury:	06/10/2010
Decision Date:	01/15/2015	UR Denial Date:	10/23/2014
Priority:	Standard	Application Received:	11/21/2014

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 Internal 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 injured worker (IW) is a 29-year-old man with a date of injury of June 10, 2015. The mechanism of injury occurred as a result of lifting a bumper cart. The IW was diagnosed with chronic neck pain, positive MRI; status post left elbow cubital tunnel release; left wrist strain, improved; chronic low back pain with 2.7 mm disc protrusion; ongoing issues with left shoulder impingement syndrome, rotator cuff tendonitis versus rotator cuff repair; lumbosacral protrusions; possibly worsening; lumbar spine degenerative disc disease at L5-S1 with protrusion; cervical spine degenerative disc disease at C6-C7; left shoulder Type II acromion impingement syndrome; and complains of depression, anxiety, and difficulty sleeping. Prior treatment have included physical therapy to the neck and upper extremities, medications, and a series of epidural steroid injections, all of which excellent but temporary relief. Pursuant to the Primary Treating Physician's Progress report and Request for Authorization dated November 17, 2017, the IW complains of constant neck pain rated 9/10. The pain radiates into his left upper extremity with associated pins and needles sensation. Current medications include Norco, Gabapentin, Robaxin, and Naprosyn. He is not attending physical therapy at this time. MRI of the cervical spine dated June 11, 2014 demonstrates mild straightening of normal lordotic curvature, usually secondary to muscle spasm. There is a 1.5 mm central posterior disc protrusion at C4-C5 level indenting the anterior aspect of the thecal sac. There is suggestion of annular fissure and 2 mm central posterior disc protrusion at C6-C7 level causing pressure over the anterior aspect of the thecal sac. The treating physician is recommending surgical intervention to include anterior cervical decompression and fusion at C5-C6 and C6-C7. The IW will require immediate postoperative immobilization with an over-the-counter cervical orthosis until x-rays reveal solid fusion, approximately 4-6 weeks. Once considered fused, the IW will require cervical rehabilitation. This will include active and active assisted range of motion, as

well as a cervical stabilization program. The provider is requesting authorization for a Solar Care FIR Heating System, and Force Stimulator Unit.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 Solar Care FIR Heating System: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines- chapter Neck and upper back - Heat / cold applications Official Disability Guidelines- chapter low back- lumbar & thoracic: Heat therapy http://www.aetna.com/cpb/medical/data/500_599/0540.html-Aetna Clinical Policy Bulletin: heating devices/number:0540 Policy

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, Infra-red Heat

Decision rationale: Pursuant to the Official Disability Guidelines, one solar care FIR heating system is not medically necessary. Infrared therapy is not recommended over other heat therapies. Where deep heating is desirable, providers may consider a limited trial of infrared therapy for treatment of acute low back pain, but only if used as an adjunct to a program of evidence-based conservative care (exercise). In this case, the injured worker is scheduled to have fusion surgery at the C5 - C6 level and C6 - C7 level. The physician request does not state whether this request is for rental or purchase for the solar care heating system. Infrared therapy is not recommended over other heat therapies pursuant to the guidelines. Consequently, one solar care FIR heating system is not medically necessary.

1 X-Force Stimulator Unit: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines- chapter Neck and upper back - Heat / cold applications Official Disability Guidelines- chapter low back- lumbar & thoracic: Heat therapy http://www.aetna.com/cpb/medical/data/500_599/0540.html-Aetna Clinical Policy Bulletin: heating devices/number:0540 Policy

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS Unit Page(s): 116. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG); Pain Section, Electric Muscle Stimulation (TENS Unit), <http://www.sevensesadm.com/force-stimulator/>

Decision rationale: Pursuant to the Chronic Pain Medical Treatment Guidelines, the Official Disability Guidelines and the product website (see attached link) X-Force stimulator is not medically necessary. The X Force Stimulator is inherently unique from TENS units and other

electrical stimulation devices. The Chronic Pain Medical Treatment Guidelines and the Official Disability Guidelines note that transcutaneous electrical nerve stimulation is not recommended as a primary treatment modality, a one-month home-based tens trial may be considered as a noninvasive conservative option. In this case, the medical records do not document a rationale for using this specific device. Additionally, transcutaneous nerve stimulation is based on a one month trial. The record does not reflect consideration for a one-month trial. Consequently, absent the appropriate clinical criteria, the X Force Stimulator is not medically necessary.