MAXIMUS Federal Services

Case Number:	CM15-0101292		
Date Assigned:	06/03/2015	Date of Injury:	02/28/2008
Decision Date:	07/08/2015	UR Denial Date:	04/28/2015
Priority:	Standard	Application Received:	05/27/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
State(s) of Licensure: California
Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 65 year old female, who sustained an industrial injury on 2/28/2008, as a result of cumulative trauma. The injured worker was diagnosed as having right shoulder sprain/strain, cervical intervertebral disc disorder with myelopathy, lumbar intervertebral disc disorder with myelopathy, trigger finger, carpal tunnel syndrome, and right wrist status post carpal tunnel release. Treatment to date has included diagnostics, steroid injections, left carpal tunnel release with trigger release, right carpal tunnel release, physical therapy, and medications. Currently (4/16/2015), the injured worker complains of pain in her bilateral shoulders, arms, and elbows, left wrist, and cervical, lumbar, and sacroiliac spines. Pain was currently rated 8/10, 5/10 at best and 9/10 at worst. She had numbness and tingling in the left hand and wrist also. Pain was better with medications, rest, and topical compounds and worse with activities of daily living. She was documented to have notable anxiety and stress. She had palpable tenderness at the cervical and lumbar spines and right anterior shoulder, along with positive axial compression. Cervical range of motion was decreased. Bilateral shoulder range of motion was decreased and left shoulder was positive for impingement. Lumbar range of motion was decreased and Kemp sign was positive. The treatment plan included an interferential unit for home use and pain relief purposes. A progress report detailing the request for Solar Care FIR (Far infrared radiant) purchase was not noted.

IMR ISSUES, DECISIONS AND RATIONALES

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

Solar Care FIR (Far-infrared radiant) Heating System for Neck, Low Back, Bilateral Wrists: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines: Shoulder - Continuous Flow Cryotherapy.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official disability guidelines Low Back chapter on infrared therapy.

Decision rationale: The patient complains of pain in bilateral upper extremities, cervical spine, thoracic spine, lumbar spine, and sacroiliac joint, rated at 5-9/10, along with anxiety and stress, as per progress report dated 04/16/15. The request is for SOLAR-CARE FIR HEATING SYSTEM PURCHASE BILATERAL WRISTS. There is no RFA for this case, and the patient's date of injury is 02/28/08. Diagnoses, as per progress report dated 04/16/15, included right shoulder sprain/strain, cervical IVD disorder with myelopathy, trigger finger, and carpal tunnel syndrome. The patient is status post right and left wrist carpal tunnel release. Medications included Cyclobenzaprine and topical compounded creams. The patient is temporarily disabled, as per the same progress report. The MTUS and ACOEM Guidelines do not address this request. However, ODG Guidelines under the Low Back chapter on infrared therapy states, "Not recommended over other heat therapies. Where deep heating is desirable, providers may consider a limited trial of IR therapy for treatment of acute lower back pain, but only if used as an adjunct to a program of evidence-based conservative care exercise." In this case, none of the progress reports discuss the request. The patient is suffering from wrist pain accompanied by numbness and tingling on the left, as per progress report dated 04/16/15. The treater does not explain why infrared heating system is preferred over conventional heat therapy. The request is for purchase but there is not documentation of a limited trail and its efficacy either, as required by ODG. Hence, the request IS NOT medically necessary.