

Case Number:	CM15-0020910		
Date Assigned:	02/10/2015	Date of Injury:	11/01/2011
Decision Date:	04/01/2015	UR Denial Date:	02/02/2015
Priority:	Standard	Application Received:	02/04/2015

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:

This 53 year old male sustained a work related injury on 11/01/2011. According to a progress report dated 11/17/2014, the injured worker was status post arthroscopic meniscectomy and debridement, right knee. He was continuing to improve, was happy with progress and the pain was diminishing. Diagnoses included improved symptomatic meniscectomy and debridement, right knee. Recommendations included physical therapy and advancement to a home exercise program. According to an attachment to a progress report dated 12/30/2014, a Solar Care FIR Heating System was prescribed to the injured worker to help him become independent and to help him take a role in the management of his symptoms. The provider noted that it was medically necessary to help cure and/or relieve the injury. The provider referenced the Official Disability Guidelines which stated that where deep heating was desirable, providers could consider home use of IR therapy for treatment especially if used as an adjunct to a program of evidence-based conservative care (exercise). The handwritten progress report submitted with this explanation was illegible. Medications prescribed included Motrin and Cyclo Cream. Another medication was prescribed but was illegible. On 02/02/2015, Utilization Review non-certified Solar Care FIR Heating System-Plus FIR Heat Pad for right shoulder and Cyclo Cream 60 grams. In regard to the Solar Care FIR Heating System-Plus Fir Heat Pad, CA MTUS ACOEM Guidelines were referenced. In regard to Cyclo Cream, the Utilization Review physician noted that there was no documentation noting a failed use of first-line therapy of antidepressant and anticonvulsants. There was no documentation of the injured worker's intolerance of these or similar medication to be taken on an oral basis. CA MTUS Chronic Pain

Medical Treatment Guidelines were cited. The decision was appealed for an Independent Medical Review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Solar Care FIR Heating System- Plus FIR Heat Pad for Right Shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints. 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 Low Back chapter on infrared therapy.

Decision rationale: This patient presents with bilateral shoulder pain. The patient is status post right knee arthroscopy from 09/30/2014. The treater is requesting SOLAR CARE FIR HEATING SYSTEM PLUS FIR HEAT PAD FOR RIGHT SHOULDER. The RFA dated 01/28/2015 shows a request for solar care FIR heating system, FIR heat pad, portable, use daily as needed. Recommended 6-8 hours per day. Purchase for the patient as long term use is most beneficial. The patient's date of injury is from 11/01/2011 and he is currently temporarily totally disabled. 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. The records do not show any previous Solar Care FIR heating system use. The treater does not explain why infrared heating system is preferred over conventional heat therapy. Furthermore, infrared therapy trial should be performed to determine its efficacy in terms of functional improvement and pain relief prior to determining if purchase is indicated. The request IS NOT medically necessary.

Cyclo cream 60 grams #2: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111-113.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical analgesic Page(s): 111-113.

Decision rationale: This patient presents with bilateral shoulder pain. The patient is status post right knee arthroscopy from 09/30/2014. The treater is requesting CYCLO CREAM 60 G QUANTITY TWO. The RFA dated 01/28/2015 shows a request for cyclo cream BID PRN #60. The patient's date of injury is from 11/01/2011 and he is currently temporarily totally disabled. The MTUS guidelines page 111 on topical analgesics states that it is largely experimental in use with few randomized controlled trials to determine efficacy or safety. It is primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have

failed. MTUS further states, Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. The records do not show a history of Cyclo cream use. It appears that the treater is requesting cyclobenzaprine cream for the patient's knee pain. The MTUS guidelines currently do not support cyclobenzaprine in topical formulation. The request IS NOT medically necessary.