

Case Number:	CM15-0215140		
Date Assigned:	11/05/2015	Date of Injury:	05/19/2011
Decision Date:	12/24/2015	UR Denial Date:	10/14/2015
Priority:	Standard	Application Received:	11/02/2015

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: Texas, California

Certification(s)/Specialty: Family Practice

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 is a 48 year old female patient who sustained a work related injury on 5-19-11. The diagnoses include neck, low back, bilateral wrist, right knee and bilateral shoulder pain. Per the doctor's note dated 9/14/15, she is status post left shoulder arthroscopic surgery on 9/11/15. She has only mild pain. Per the progress notes dated 7-11-15 and 8-6-15, she had complaints of severe neck pain, severe bilateral shoulder pain, left worse than right; severe mid back pain; severe low back pain, moderate to severe right knee pain, both wrists pain, left worse than right. Physical exam dated 8-6-15 revealed decreased bilateral shoulder range of motion, left worse than right; tenderness of the acromioclavicular joint bilaterally, more on the left than the right. Current medications include Tramadol, Flexeril, Xanax, Naproxen and topical cream. Her surgical history includes C-sections, gall bladder surgery, left foot surgery, tumor removal from the right breast, bladder surgery and recent left shoulder surgery on 9/11/15. She has had an EMG/NCS dated 7/17/15, which revealed right carpal tunnel syndrome. Treatments have included medications and shoulder injections. She is not working. The treatment plan includes requests for an X-Force with Solar care device and to continue medications. The Request for Authorization dated 8-7-15 has a request for an X-Force stimulator unit plus supplies. In the Utilization Review dated 10-14-15, the requested treatment of a Retro Solar Care FIR heating system is not medically necessary.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective solar care FIR heating system: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Physical Medicine.

Decision rationale: The requested DME is meant to provide heat therapy, which is a kind of passive physical medicine treatment. Per the CA MTUS chronic pain guidelines, "The use of active treatment modalities (e.g., exercise, education, activity modification) instead of passive treatments is associated with substantially better clinical outcomes." The rationale for not using simple hot packs versus the use of this DME- Solarcare Fir Heating System with Pad was not specified in the records provided. Failure to previous conservative therapy including pharmacotherapy and physical therapy was not specified in the records provided. Retrospective solar care FIR heating system was not medically necessary for this patient.