

<b>Case Number:</b>	CM15-0036314		
<b>Date Assigned:</b>	03/04/2015	<b>Date of Injury:</b>	12/17/2009
<b>Decision Date:</b>	04/14/2015	<b>UR Denial Date:</b>	02/09/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/26/2015

### 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: Georgia

Certification(s)/Specialty: Anesthesiology, Pain Management

### 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 44 year old male, who sustained an industrial injury on 12/17/2009. He reports neck and low back injury with the mechanism of injury was not provided for review. Diagnoses include lumbar radiculopathy, left shoulder pain and status post left shoulder surgery x 2. Treatments to date include surgery, physical therapy and Interferential unit therapy and medication management. A progress note from the treating provider dated 1/14/2015 indicates the injured worker reported left shoulder pain, neck pain and low back pain. On 2/9/2015, Utilization Review non-certified the request for purchase of solar care FIR heating system to the left shoulder and cortisone shoulder injection to the left shoulder, citing MTUS, ACOEM and Official Disability Guidelines.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Purchase of Solar Care FIR Heating System left shoulder:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 201-205. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Treatment Index, 11th Edition (web), 2014, Knee & Leg, Diathermy.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 250.

**Decision rationale:** Purchase of Solar Care FIR Heating System left shoulder is not medically necessary. The American College of Environmental Medicine states that applications of heat and cold are recommended as method of symptom control for shoulder complaints. Additionally, at home applications of cold during first few days of acute complaint is recommended; thereafter, application of heat or cold as patient prefers, unless swelling persists, then use cold. The ACOEM, supports simple low-tech applications of heat and cold as opposed to the Solar Care FIR Heating System being proposed. Finally, the claimant's condition is chronic. The ACOEM supports this therapy for acute conditions; therefore, the requested therapy is not medically necessary.

**Cortisone Steroid Injection for the left shoulder:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 201-205. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Treatment Index 11th Edition (web), 2014, Knee & Leg, Corticosteroid injections.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder Complaints: Treatment Consideration.

**Decision rationale:** Cortisone Steroid Injection for the left shoulder is not medically necessary. CA MTUS guidelines references ODG and states that invasive techniques have limited proven value. If pain with elevation significantly limits activities, a subacromial injection of local anesthetic and a corticosteroid preparation may be indicated after conservative therapy (i.e. strengthening exercises and non-steroidal anti-inflammatory drugs for two to three weeks. The total number of injections should be limited to three per episode, allowing for assessment of benefit between injections. The guidelines recommend at least 2-3 weeks of conservative therapy prior to attempting steroid injections of the shoulder. There is also lack of documentation of failed conservative therapy; therefore, the requested service is not medically necessary.