

<b>Case Number:</b>	CM15-0111074		
<b>Date Assigned:</b>	06/17/2015	<b>Date of Injury:</b>	02/26/2012
<b>Decision Date:</b>	07/16/2015	<b>UR Denial Date:</b>	05/06/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/09/2015

### 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 51 year old female, who sustained an industrial injury on 2/26/12. She reported initial complaints of neck, mid back and low back pain. The injured worker was diagnosed as having right shoulder rotator cuff tendinitis with impingement. Treatment to date has included right shoulder/trigger point injections; physical therapy; urine drug screening; medication. Diagnostics included EMG/NCV study lower extremities (5/6/13); MRI cervical spine (7/18/13); MRI right shoulder (7/18/13); MRI lumbar spine (10/29/13). Currently, the PR-2 notes dated 4/22/15 indicated the injured worker complains of right shoulder pain rated at 6/10 and low back pain rated at 6/10. The notes are in the form of a check marked sheet and indicated objectives of: antalgic gait, stiffness, protectively. She is a status post right shoulder surgery but no indication of date of that operation. Other notes indicated a request for right shoulder surgery was made indicating procedure for a right shoulder arthroscopy with acromioplasty, Mumford procedure, and rotator cuff repair. The provider sends information regarding a Solar care FIR heating system and FIR heat pad portable. This is his request for authorization at this time.

### 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:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): Chapter 9, pages 195-220, Hot/cold therapy. Decision based on Non-MTUS Citation ODG, Shoulder/ arm, Diathermy/ heat therapy, pages 911.

**Decision rationale:** Regarding Hot/Cold therapy, guidelines state it is recommended as an option after surgery, but not for nonsurgical treatment. The request for authorization does not provide supporting documentation for solar care system without duration beyond the guidelines criteria. There is no documentation that establishes medical necessity or that what is requested is medically reasonable outside recommendations of the guidelines which note local application of heat or cold is as effective as those performed by therapists and high tech devices have not demonstrated superior efficacy over the use of traditional non-motorized heating pad modalities. MTUS Guidelines is silent on specific use of hot/cold compression therapy, but does recommend standard cold pack for post exercise. ODG Guidelines specifically addresses the short-term benefit of cryotherapy post-surgery; however, limits the use for 7-day post-operative period as efficacy has not been proven after. The Solar care Fir heating system is not medically necessary and appropriate.

**Fir heat pad, portable:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Low-Level Laser Therapy (LLLT), Cold lasers/ Non-thermal infrared therapy, page 57.

**Decision rationale:** Per Guidelines, infrared therapy remains experimental and investigational as meta-analysis studies concluded that there are insufficient data to draw firm conclusions about the effects of infrared therapy and due to a lack of adequate evidence in the peer-reviewed published medical literature regarding the effectiveness of infrared therapy. Submitted reports have not adequately demonstrated medical indication or necessity beyond guidelines recommendations. The Fir heat pad, portable is not medically necessary and appropriate.