

<b>Case Number:</b>	CM15-0094587		
<b>Date Assigned:</b>	05/20/2015	<b>Date of Injury:</b>	04/13/2011
<b>Decision Date:</b>	06/29/2015	<b>UR Denial Date:</b>	04/29/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/15/2015

### 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: Internal Medicine

### 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 56 year old male who sustained an industrial injury on 4/13/11. The mechanism of injury is unclear. The injured worker is ten days post-op arthroscopic subacromial decompression and partial distal claviclectomy and has intermittent, severe pain. His continuous passive motion machine is up to 125. He has mild right wrist and right knee pain and moderate neck pain. On physical exam the right shoulder range of motion is decreased and his pain level is 2-4/10 with range of motion. Medications are Norco, Prilosec and Xanax. Diagnoses include right knee medial meniscus tear plus chondromalacia of the patella; left knee overuse syndrome plus chondromalacia of the patella; bilateral shoulder posttraumatic arthrosis of the acromioclavicular joints, secondary to overuse; stress, depression and anxiety; insomnia; gastroesophageal reflux disease; sexual dysfunction; cervical C 5-6 herniated nucleus pulposus; right wrist sprain from fall (2/11/12); status post left shoulder arthroscopic decompression and partial claviclectomy; status post right shoulder arthroscopic subacromial decompression and partial distal claviclectomy. Treatments to date include physical therapy, acupuncture, chiropractic therapy, medications. Diagnostics include x-rays of the clavicle (4/23/15) show excellent resection; x-ray of the cervical spine (10/10/14) showing moderate to severe degenerative disease, disc collapse; MRI of the cervical spine (10/8/14) showed cervical degenerative disc disease, disc collapse. The utilization Review dated 4/29/15 reviewed the request for Solar care, infrared heat system for purchase for the back.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Solar care, infrared heating system for the back, purchase:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 9 Shoulder Complaints, Chapter 12 Low Back Complaints Page(s): 173, 203, 212, 300. Decision based on Non-MTUS Citation ODG Low Back Infrared therapy. Work Loss Data Institute <http://www.guideline.gov/content.aspx?id=47586> ACOEM 3rd edition <http://www.guideline.gov/content.aspx?id=38438>.

**Decision rationale:** Medical Treatment Utilization Schedule (MTUS) addresses passive modalities. American College of Occupational and Environmental Medicine (ACOEM) Chapter 12 Low Back Complaints indicates that physical modalities such as massage, diathermy, cutaneous laser treatment, ultrasound, transcutaneous electrical neurostimulation (TENS) units, percutaneous electrical nerve stimulation (PENS) units, and biofeedback have no proven efficacy in treating acute low back symptoms. Insufficient scientific testing exists to determine the effectiveness of these therapies. American College of Occupational and Environmental Medicine (ACOEM) Chapter 8 Neck and Upper Back Complaints indicates that there is no high-grade scientific evidence to support the effectiveness or ineffectiveness of passive physical modalities such as traction, heat/ cold applications, massage, diathermy, cutaneous laser treatment, ultrasound, transcutaneous electrical neurostimulation (TENS) units, and biofeedback. American College of Occupational and Environmental Medicine (ACOEM) Chapter 9 Shoulder Complaints states that physical modalities, such as massage, diathermy, cutaneous laser treatment, ultrasound treatment, transcutaneous electrical neurostimulation (TENS) units, and biofeedback are not supported by high-quality medical studies. Table 9-6 Summary of Recommendations for Evaluating and Managing Shoulder Complaints indicates that passive modalities are not recommended. American College of Occupational and Environmental Medicine (ACOEM) 3rd edition indicates that infrared therapy is not recommended for cervicothoracic disorders or chronic low back disorders. Official Disability Guidelines (ODG) Shoulder (Acute & Chronic) states that thermotherapy are under study. For several physical therapy interventions and indications (eg, thermotherapy using heat, therapeutic exercise, massage, electrical stimulation, mechanical traction), there was a lack of evidence regarding efficacy. ODG guidelines indicate that infrared heat is not recommended over other heat therapies. Work Loss Data Institute guidelines indicate that diathermy is not recommended for neck and upper back disorders. Work Loss Data Institute guidelines indicate that infrared therapy is not recommended for low back disorders. The orthopedic report dated 3/23/15 documented a history of right knee medial meniscus tear plus chondromalacia of the patella, left knee overuse syndrome plus chondromalacia of the patella, bilateral shoulder posttraumatic arthrosis of the acromioclavicular joints, cervical C5-6 herniated nucleus pulposus of 4 mm, right wrist sprain, status post arthroscopic medial meniscectomy and chondroplasty patella of the right knee, status post left shoulder arthroscopic decompression and partial claviclectomy, and status post right shoulder arthroscopic subacromial decompression and partial distal claviclectomy. Solar care infrared heating system for the back purchase was requested

03/06/15. ODG guidelines indicate that infrared heat is not recommended over other heat therapies. Work Loss Data Institute guidelines indicate that infrared therapy is not recommended for low back disorders. The request for infrared therapy device is not supported by clinical practice guidelines. Therefore, the request for Solar care infrared heating system for the back is not medically necessary.