

Case Number:	CM13-0039397		
Date Assigned:	07/02/2014	Date of Injury:	11/21/2000
Decision Date:	07/31/2014	UR Denial Date:	10/18/2013
Priority:	Standard	Application Received:	10/28/2013

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. The expert reviewer is Board Certified in Physical Medicine & Rehabilitation, and is licensed to practice in Illinois. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 62-year-old female who reported an injury on 11/21/2000. The mechanism of injury was not provided with the documentation. The injured worker's prior treatments were noted to be medications, laser therapy, physical therapy, epidural steroid injections, and transcutaneous electrical nerve stimulation. The injured worker's diagnoses were noted to be chronic low back pain secondary to lumbosacral degenerative disc disease with facet arthropathy at L5-S1. The injured worker had a clinical evaluation on 01/15/2014. The subjective complaints included complaints of pain in her back and left lower extremity. She noted with medication she is able to function and without pain medication she states that she is bed-bound due to severe pain. The objective findings included tenderness on palpation on the lateral side of her left ankle and motor strength in the lower extremity was 5/5, proximal and distal. Sensation was intact. No drowsiness or dizziness noted. The treatment plan was to continue with Norco, refill methocarbamol, and followup with doctor for a trial of spinal cord stimulator to help with neuropathic pain. The provider's rationale for the requested K-laser treatment to the lumbar spine with [REDACTED] was not provided within the documentation. A request for authorization of medical treatment was not provided within the documentation.

IMR ISSUES, DECISIONS AND RATIONALES

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

K-laser treatment to lumbar spine with [REDACTED]: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Low-Level Laser Therapy (LLLT). Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back, Low-Level Laser Therapy (LLLT).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Low-Level Laser Therapy (LLLT) Page(s): 57.

Decision rationale: The CA MTUS Chronic Pain Medical Treatment Guidelines do not recommend low level laser therapy. There has been interest in using low level lasers as a conservative alternative to treat pain. Low level lasers, also known as "cold lasers", and nonthermal layers, refer to the use of a red beam or near-infrared lasers with a wave length between 600 and 1000nm and wattage from 5/500 mW. When applied to the skin, these lasers produce no sensation and do not burn the skin. Because of the low absorption by human skin, it is hypothesized that the laser light can penetrate deeply into the tissues where it has a photobiostimulative effect. Given the equivocal or negative outcomes from a significant number of randomized clinical trials, it must be concluded that the body of evidence does not allow conclusions other than that the treatment of most pain syndromes with low level laser therapy provides at best the equivalent of a placebo effect. The clinical evaluation on 01/15/2014 notes the injured worker reporting efficacy with pain medication. There is no additional evidence within the documentation to support a necessity for laser treatment. In addition, the request for the K-laser treatment to the lumbar spine does not indicate a frequency or number of visits requested. Therefore, the request for K-laser treatment to the lumbar spine with [REDACTED] is non-certified.