MAXIMUS Federal Services

Case Number:	CM14-0110124		
Date Assigned:	09/16/2014	Date of Injury:	02/24/2014
Decision Date:	10/16/2014	UR Denial Date:	06/27/2014
Priority:	Standard	Application Received:	07/14/2014

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 Occupational Medicine, and is licensed to practice in California. 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 patient is a 43-year-old male who has submitted a claim for bilateral hand, wrist, forearm, elbow, and shoulder tendinitis secondary to overuse associated with an industrial injury date of 02/24/2014. Medical records from 05/06/2014 to 07/31/2014 were reviewed and showed that patient complained of bilateral upper extremity pain graded 7/10. Physical examination revealed no tenderness, intact sensation, strength, and DTRs of upper extremities, and positive Phalen's tests bilaterally. Treatment to date has included 12 visits of acupuncture, massage, physical therapy, chiropractic care, ice, heat, and laser therapy (unspecified date). Of note, patient reported pain relief (not quantified) with aforementioned treatments for unspecified duration (06/23/2014). Utilization review dated 06/27/2014 denied the request for because evidence for K-laser effectiveness of this treatment was lacking.

IMR ISSUES, DECISIONS AND RATIONALES

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

K-Laser: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 57.

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

Decision rationale: As stated on page 57 of the CA MTUS Chronic Pain Medical Treatment Guidelines, low-level laser therapy (LLLT) is not recommended for treatment of pain. 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. In this case, the patient underwent previous laser therapy (unspecified date) with noted un-quantified pain relief. It was noted that patient also reported pain relief with acupuncture, physical therapy, chiropractic care, and ice and heat applications. The guidelines do not recommend laser therapy as it has been shown to be no effective than placebo. It is unclear as to why laser therapy is needed when other evidence-based approaches provide pain relief. In addition, the request likewise failed to specify the body part to be treated. Therefore, the request for K-laser is not medically necessary.