

Case Number:	CM14-0021411		
Date Assigned:	05/07/2014	Date of Injury:	06/19/2001
Decision Date:	07/09/2014	UR Denial Date:	02/11/2014
Priority:	Standard	Application Received:	02/20/2014

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 Physical Medicine and Rehabilitation 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 injured worker is a 49-year-old male who reported an injury on 06/19/2011 secondary to an unknown mechanism of injury. The injured worker was evaluated on 01/17/2014 for reports of bilateral elbow and right shoulder pain. The exam noted tenderness to the right trapezius, clicking sensation on palpation and motion of the right shoulder. The right wrist was noted to have slight tenderness at the volar aspect on deep palpation. The right elbow exam noted exquisite tenderness on the lateral epicondyle as well as the extensor compartment. The diagnoses included right lateral epicondylitis, right De Quervain's tenosynovitis, right extensor tendonitis, right wrist sprain, cervical sprain, and right shoulder sprain. The treatment plan included right shoulder cortisone injection, cold laser therapy, and Biofreeze. The request for authorization dated 01/17/2014 with rationale was included in the documentation provided.

IMR ISSUES, DECISIONS AND RATIONALES

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

RIGHT SHOULDER CORTISONE INJECTION: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints
Page(s): 201-205.

Decision rationale: The ACOEM Guidelines state if pain with elevation significantly limits activities, a subacromial injection of local anesthetic and a corticosteroid preparation may be indicated after conservative therapy for two to three weeks. There is a significant lack of evidence of exhaustion of conservative therapies such as physical therapy and NSAIDs. Therefore, based on the documentation provided, the request is not medically necessary and appropriate.

DIO WAVE CLASS IV LASER SYSTEM THERAPY: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation CIGNA:

http://www.cigna.com/assets/docs/health-care-professionals/coverage_positions/mm_0115_coveragepositioncriteria_lowlevel_laser_therapy.pdf, and the AETNA Clinical Policy Bulletin: Cold Laser and High-Power Laser Therapies http://www.aetna.com/cpb/medical/data/300_399/0363.html.

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

Decision rationale: The MTUS Chronic Pain Guidelines do not recommend the use of low level laser therapy, despite some positive findings. The MTUS Chronic Pain Guidelines further state that data is lacking on how low-level laser therapy (LLLT) effectiveness is affected by four important factors: wavelength, treatment duration of LLLT, dosage and site of application over nerves instead of joints. Therefore, based on the documentation provided, the request is not medically necessary and appropriate.

BIOFREEZE - LOCAL APPLICATION BID # 2 TUBES: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TOPICAL ANALGESIC.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, Biofreeze cryotherapy gel.

Decision rationale: The Official Disability Guidelines recommend Biofreeze as an optional form of cryotherapy for acute pain. The injured worker's date of injury was in 2011 which exceeds the time frame to be considered acute. There is also a significant lack of evidence of a new report of acute pain in the documentation provided. Furthermore, the specific body area of use is not indicated in the documentaion provided. Therefore, based on the documentation provided, the request is not medically necessary and appropriate.