

<b>Case Number:</b>	CM15-0086103		
<b>Date Assigned:</b>	05/08/2015	<b>Date of Injury:</b>	01/21/1997
<b>Decision Date:</b>	06/11/2015	<b>UR Denial Date:</b>	04/17/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/05/2015

### 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: Emergency 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 68 year old male who sustained an industrial injury on 1/21/1997. His diagnoses, and/or impressions, are noted to include: lumbar discogenic pain and radiculitis; cervical discogenic pain; bilateral shoulder internal derangement; left elbow pain; paresthesia; stiffness/restriction/ general myospasms; thoracalgia; lumbalgia; unspecified idiopathic peripheral neuropathy; peripheral neuropathy; myofascial pain syndrome; and sciatica. No current imaging studies are noted. His treatments have included a neurologic consultation (11/3/11); chiropractic treatments which included other modality treatments - effective; a home exercise program; diagnostic laboratories; and supplement with medication management. History notes accumulated trauma in his lower back due to his profession; bilateral shoulder surgeries, left elbow cubital tunnel release and right wrist carpal tunnel release surgeries; and melanoma that had been excised and is with regular dermatology surveillance. It is noted that a Toronto Clinical Scoring System/QST exam of the lower extremities was performed which resulted in the diagnosis of unspecified idiopathic peripheral neuropathy, said to validate his complaints of pain that shoots down into his legs, low back and sciatica. Progress notes of 2/20/2015 reported numbness, sharp electrical pain with cramping and burning pain; a painful gait; poor balance; prickling/tingling discomfort and cold feet. No objective findings were noted to be included in these progress notes. The letter of 4/13/2015 notes the physician's requests for treatments to include Hako-Med, Pro-Neurolight and decompression therapies for these complaints.

## IMR ISSUES, DECISIONS AND RATIONALES

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

### **30 Sessions of Hako med therapy: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 146-147. Decision based on Non-MTUS Citation Official Disability Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy Page(s): 114-117.

**Decision rationale:** There is very little medical information concerning this claimed therapy. Hako med is a company that has developed a device called ProElect that claims to use a proprietary electrical stimulation called "Horizontal Therapy". Review of website provides almost no medical information except for some marketing jargon. It appears to be a type of transcutaneous electrical nerve stimulation therapy. Other types of treatment modality is not defined and can therefore not be reviewed. This device will be reviewed as a TENS device. As per MTUS Chronic pain guidelines, TENS (Transcutaneous Electrical Nerve Stimulation) may be recommended only if it meets criteria. Evidence for its efficacy is poor. Pt does not meet criteria to recommend TENS. TENS is only recommended for neuropathic or Complex Regional Pain Syndrome (CRPS) pain. Patient has a diagnosis of radicular pain. There is no documentation of failures of multiple conservative treatment modalities. Guidelines recommend use only with Functional Restoration program which is not documented. There is no documentation of short or long term goal of TENS unit. There is no documentation of an appropriate 1month trial of TENS. Patient had reportedly undergone similar "therapy" in the past and has no documented objective improvement in pain or function. Hako-Med is not medically necessary.

### **30 Sessions of Proneuro light therapy: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 146-147. Decision based on Non-MTUS Citation Official Disability Guidelines.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG: Pain: Low level laser therapy (LLLT).

**Decision rationale:** MTUS Chronic pain and ACOEM Guidelines do not have any sections that relate to this topic. As per Official Disability Guidelines, Low Level Laser therapy like Proneuro light is not recommended. Evidence to supports its efficacy is poor to negative. Proneuro light therapy is not medically necessary.

### **30 Sessions of decompression therapy: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 146. Decision based on Non-MTUS Citation Official Disability Guidelines.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG: Low Back: IDD therapy (intervertebral disc decompression).

**Decision rationale:** MTUS Chronic pain and ACOEM Guidelines do not have any sections that relate to this topic. As per Official Disability Guidelines, decompression therapy is not medically recommended. It has no long term benefit and is not effective. Decompression therapy is not medically necessary.