

<b>Case Number:</b>	CM15-0018374		
<b>Date Assigned:</b>	02/06/2015	<b>Date of Injury:</b>	05/13/2014
<b>Decision Date:</b>	03/25/2015	<b>UR Denial Date:</b>	01/12/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/30/2015

### 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 47 year old male, who sustained an industrial injury on May 13, 2014. He has reported intractable back pain with associated insomnia, stiffness and decreased ability to interact socially. The diagnoses have included lumbar radiculopathy and sprain and strain of the lumbosacral spine. Treatment to date has included radiographic imaging, diagnostic studies, surgical intervention, conservative therapies, pain medications, physical therapy and work restrictions. Currently, the Injured Worker complains of intractable back pain with associated insomnia, stiffness and decreased ability to interact socially. The injured worker reported an industrial injury in 2014, resulting in intractable back pain. It was noted she was non-responsive to conservative therapies. She was treated with continued pain medications. On September 2, 2014, evaluation revealed the injured worker reported feeling better after physical therapy however the pain persisted. On January 5, 2015, evaluation revealed continued pain. Objective exam reveals no antalgic gait, tenderness to lumbar region, decreased range of motion, decreased R sided L4-5 dermatome. Positive straight leg raise. On January 12, 2015, Utilization Review non-certified a request for Hako Med Neuromuscular Re-Education Sessions 5 Visits, Lumbar Spine, noting the MTUS, ACOEM Guidelines, (or ODG) was cited. On January 30, 2015, the injured worker submitted an application for IMR for review of requested Hako Med Neuromuscular Re-Education Sessions 5 Visits, Lumbar Spine.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Hako Med Neuromuscular Re-Education Sessions 5 Visits, Lumbar Spine, Per 01/05/15**  
**Form:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS) Page(s): 118-120.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy Page(s): 114-120. Decision based on Non-MTUS Citation <http://www.hako-med.com>

**Decision rationale:** This request appears to be sessions involving use of a device. Information concerning this device is sparse. The website and online information is basically sales information and does not provide any valid clinical data. The device uses a proprietary "Horizontal Therapy" which is a trade name for some unknown electrotherapy. Review of limited literature shows that Hako-Med neuromuscular device is a multi-function electrical stimulator that has Galvanic Stimulation, Transcutaneous electrical nerve stimulation (TENS), Interferential current stimulation and Neuromuscular electrical stimulation (NMES). The unit is requested for patient's low back pain. Since this unit has multiple functions, the determination will be made if the preponderance of functions are not recommended as per MTUS guidelines.1) Galvanic Stimulation: Not recommended. Considered investigational. Very poor supporting evidence of efficacy.2) TENS: Not recommended as a primary treatment modality. Some evidence in neuropathic pain use. Patient fails criteria for use as per MTUS guidelines.3) Interferential current stimulation: Not recommended in isolated use.4) NMES: Not recommended. Only evidence to support use in stroke and not in chronic pain. There appears to be also some sort of pneumatic function on this device as well. Patient failed to meet any criteria for any of the unit's functions. Since all functions are not recommended with 2 functions (Galvanic Stimulation and NMES) not recommended under any chronic pain situation, the entire unit and sessions are not recommended.