

Independent Resolutions Inc.

An Independent Review Organization

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DATE OF REVIEW: July 26, 2007

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Prolotherapy (investigational/experimental)

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION

Board Certified Orthopedic Surgeon

REVIEW OUTCOME

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

- Upheld (Agree)
- Overturned (Disagree)
- Partially Overturned (Agree in part/Disagree in part)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Office notes, Dr. 03/28/06, 05/11/06 and 10/03/06

Lumbar, cervical, left hip and left shoulder x-rays, 05/05/06

Head and lumbar CT scan, 05/12/06

EMG/NCS, 06/26/06

Lumbar MRI, 07/07/06

Independent Medical Evaluation, Dr. 07/20/06

DDE, Dr. 09/07/06

Functional capacity evaluation, 09/08/06 and 03/15/07

Office note, Dr. 10/17/06

Computerized muscle testing and range of motion, 10/18/06, 11/29/06 and 03/14/07

Letter, Dr. 11/29/06

Initial therapy note, Dr. 11/30/06

Office notes, Dr. 12/13/06, 01/24/07 and 04/24/07

Interim report, Dr 05/02/07, 05/16/07

Pre-authorization requesting prolotherpay, Dr. 05/04/07

Review, Dr. 05/17/06
Letter, Dr. 05/18/06
Review, Dr. 05/29/06

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a male driver who was involved in a roll over motor vehicle accident in his truck. He reported neck, low back, head, bilateral shoulder, left hip, chest and right upper leg injuries. He initially treated with his company physician with medications. He started chiropractic care on 03/28/06. Multiple radiographs from 05/05/06 noted six millimeter retrospondylolisthesis L4 on L5, normal right hip, unremarkable left shoulder and moderate cervical spondylosis. CT evaluation of the head performed on 05/12/06 was negative and lumbar study from the same date noted bilateral pars defects at L5 with severe foraminal compromise; L4-5 disc herniation with moderately severe left lateral recess compromise; as well as L2-3 and L3-4 moderate foraminal compromise. Electrodiagnostic studies completed on 06/26/06 identified an acute left L4-5 radiculopathy. MRI evaluation of the lumbar spine conducted on 07/07/06 again demonstrated L4-5 disc herniation with bilateral left greater than right foraminal compromise and L5 nerve root compression, and L5-S1 foraminal encroachment with contact of the bilateral L5 nerve roots. The claimant continued to treat with chiropractic modalities, electrical stimulation, medications, activity modification and physical therapy. A designated doctor evaluation from 09/07/06 felt the claimant was at maximum medical improvement with a zero percent impairment rating. A functional capacity evaluation conducted on 09/08/06 felt the claimant could perform medium duty work, which met his job description. The claimant's treating chiropractor felt the claimant was not at maximum medical improvement and kept the claimant off work. Orthopedic evaluation by Dr. performed on 10/17/06 noted positive right straight leg raise, positive right Lasègue, and decreased sensation along the right lateral calf and dorsal foot. Dr. diagnosed central L4-5 disc herniation with lumbar radiculopathy not responding to conservative modalities and recommended hemilaminectomy discectomy right L4-5. The claimant declined surgical intervention and work hardening was recommended. The claimant began treatment with Dr. a Chiropractor, on 11/30/06 for the cervical spine, lumbar spine, and left shoulder. On 12/13/06 Dr. indicated the claimant was a diabetic and added Soma and Feldene to the claimant's treatment regimen. The claimant was also diagnosed with sacroiliac joint dysfunction. Multiple cervical trigger point injections were given on 01/27/07 with reported benefit. Another functional capacity evaluation was completed on 03/15/07 with another recommendation for work hardening. A left sacroiliac joint and sacrotuberous injection were given on 04/24/07. Prolotherapy was requested on 05/14/07.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION.

Physician discussion was not required for this review. Based on the records provided for review the requested prolotherapy would not be recommended as medically necessary.

The claimant has been treating for multiple complaints related to his motor vehicle injury that included cervical, thoracic and lumbar spine as well as sacroiliac joints. The request for prolotherapy for the back was not specific to a level or area. The claimant's current examination findings and functional deficits are not noted. While it appears the claimant has some ongoing complaints that have not responded to extensive modalities, the

efficacy of prolotherapy remains controversial in peer reviewed literature. The referenced studies provided in Dr.'s pre-authorization request fail to provide recent supportive studies and indicate the results demonstrate that prolotherapy may be effective at reducing spinal pain. The additional studies referenced in his appeal letter were more current; however, they only suggested that prolotherapy is effective for many musculoskeletal conditions. Multiple study reviews by both the Official Disability Guidelines and ACOEM Guidelines have failed to provide definitive or superior efficacy for the procedure. Use of the modality has not been utilized as a standard of care. Based on a lack of long term peer review support of the modality and in keeping with the Official Disability Guidelines, the use of prolotherapy would not be recommended as medically reasonable and would be considered investigational.

Official Disability Guidelines Treatment in Worker's Comp 2007 Updates; Lumbar-Prolotherapy:

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE
- AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES
- DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES
- EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN
- INTERQUAL CRITERIA
- MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS
- MERCY CENTER CONSENSUS CONFERENCE GUIDELINES
- MILLIMAN CARE GUIDELINES
- ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES
- PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR
- TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

- TEXAS TACADA GUIDELINES
- TMF SCREENING CRITERIA MANUAL
- PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE
(PROVIDE A DESCRIPTION)
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME
FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)