



Medwork Independent Review

5840 Arndt Rd., Ste #2
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NOTICE OF MEDWORK INDEPENDENT REVIEW DECISION WORKERS' COMPENSATION - WC

Date: March 19, 2013

DATE OF REVIEW: 3/15/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Physical medical procedure. Six visits for prolotherapy, low level laser therapy, and plasma rich protein, and self-care management therapy, if necessary.

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

Texas State Licensed MD Board Certified Anesthesiology & Pain Management Physician

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)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

1. Texas Dept of Insurance Assignment to Medwork 2/27/2013,
2. Notice of assignment to URA 2/13/2012,
3. Confirmation of Receipt of a Request for a Review by an IRO 2/27/2013
4. Company Request for IRO Sections 1-4 undated
5. Request For a Review by an IRO patient request 2/26/2013
6. Letters from Attorney at Law 3/4/2013, Texas utilization review 10/22/2012, medical records 10/22/2012, Texas utilization review preauthorization services 9/13/2012, medical records 9/12/2012, letter from physician 6/27/2012, medical documents from orthopedic facility 5/25/2012, neuropsychological evaluation 5/23/2012, neuropsychological evaluation 5/10/2012, letter from sumantra massage, results of neuropsychological evaluation 4/30/2012, exit physical evaluation 4/19/2012, 3/29/2012, medical notes from chiropractor 3/29/2012, medical notes from physician 1/19/2012, medical notes from chiropractor 1/13/2012, 1/2/2012, 12/30/2011, 12/28/2011, 1/4/2011, medical notes from imaging facility 11/30/2011, insurance coverage information.



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PATIENT CLINICAL HISTORY:

The patient is a male who sustained an injury on xxxxxx in the form of a post-concussive syndrome and severe cervical sprain and strain with a demonstration of a mild C3-C4 spondylotic bulge that really is difficult to ascertain whether or not the injury had caused the mild bulge. His pain is reproduced with palpation and with facet loading maneuvers suggesting some facet mediated pain and myofascial pain.

He sustained an injury on xxxxxx after he suffered a concussion during a hockey game. His symptoms have been consistent with post concussion syndrome including slow thought process, trouble multi-tasking, coordination problems, blurred vision, headaches, fatigue, light sensitivity, and signs and symptoms of adjustment disorder diagnosed by his physician. He also has had somatic complaints including pain with associated tenderness in the cervical paraspinal region and upper traps bilaterally. Orthopedic testing has showed tenderness to palpation in the medial and lateral paraspinal region, the cervical region, and pain with facet loading maneuvers. There has been a request for prolotherapy, low level laser therapy, and, if necessary, plasma rich protein and self care management training x6 visits for what is described for a diagnosis of severe neck sprain and strain.

An MRI of the cervical spine was done on 01/19/2012, which revealed a mild C3-C4 annular bulge more prominent on the right than the left causing right greater than left foraminal encroachment with no evidence of significant central canal stenosis or cord deformity. MRI of the head and CT of the head were unremarkable.

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

To date he has undergone conservative treatment including therapy and medication management. In regard to prolotherapy, ODG guidelines states it is not recommended. Prolotherapy is described as a procedure for strengthening lax ligaments by injecting sclerosing agents into the torn and stretched ligament or tendon. While ODG states that this is not recommended, the physical exam provided on several occasions did not really reveal any signs of ligament laxity that would support the use of a sclerosing type treatment. Additionally, prolotherapy has been investigated as a treatment for various etiologies of pain, including arthritis, degenerative disk disease, fibromyalgia, tendonitis, plantar fasciitis, and in all studies the effects or prolotherapy did not significantly exceed placebo effects. In regard to platelet rich plasma, the guidelines states that this remains under study, and in regard to utilization in the patient's case, this is a regenerative type injection therapy process. There is no suggestion on physical exam that the patient's pain is related to ligament laxity. Therefore it is not recommended.

In regard to laser treatment, this treatment, per guidelines, is not recommended and meta-analysis concluded that there is insufficient data to draw from conclusions about the effects of LLLT for treatments for pain.



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There was no suggestion through his physical examinations per documentation provided that there was significant ligament laxity and therefore regenerative injection therapy in the form of prolotherapy and PRP is not only, not recommended per ODG, but also through his physical examination.

The denial of these services is upheld.

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)