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| Case Number: | CM13-0001761 | | |
| Date Assigned: | 05/02/2014 | Date of Injury: | 04/05/2012 |
| Decision Date: | 06/02/2014 | UR Denial Date: | 07/05/2013 |
| Priority: | Standard | Application Received: | 07/17/2013 |

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 Anesthesiology, has a subspecialty in Pain Management and is licensed to practice in Georgia. 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 claimant is a 49-year-old male presenting with chronic pain following a work-related injury on April 5, 2012. The claimant complains of pain in his upper back and neck radiating 7 out of 10 and associated with paresthesia and pain radiating around the abdominal area. MRI of the thoracic spine on October 8, 2012 revealed focal disc herniation. Carotid ultrasound on October 8, 2012 was negative for any findings. EMG nerve conduction study of the left upper extremity on February 8, 2013 was normal. MRI of the cervical spine on February 12, 2013 showed intradiscal space or at C5-6 that produced a moderate amount of artifact, mild foraminal narrowing bilaterally, and mild dorsal osteophytosis without evidence of spinal stenosis. The claimant was diagnosed with lumbar ago, degenerative disc disease of the cervical and lumbar spine and a T6-7 disc herniation. On April 25, 2013 the claimant reported that he was not getting any better in his pain in his upper back and neck was worse. On physical exam the claimant had decreased range of motion of the thoracic spine where he lacked about 30% of movement in most planes, and tight bands with spasm in the thoracic paraspinal muscles and trapezius muscles. The claimant has tried physical therapy, home exercises, massage, TENS unit, acupuncture and myofascial release without benefit. Prolotherapy-D5W, for series, and check to neck every 3-4 months was recommended.

IMR ISSUES, DECISIONS AND RATIONALES

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

PROLOTHERAPY - D5W, 4 SERIES, INJECT TO NECK EVERY 3-4 MONTHS:

Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Prolotherapy Page(s): 97-98.

Decision rationale: Prolotherapy - D5W, 4 series, inject to neck every 3-4months is not medically necessary. Prolotherapy describes a procedure for strengthening lax ligaments by injecting proliferating agents/sclerosing solutions directly into torn or stretched ligaments or tendons or into a joint or adjacent structures to create scar tissue in an effort to stabilize a joint. Agents used with Prolotherapy have included zinc sulfate, psyllium seed oil, combinations of dextrose, glycerine and phenol, or dextrose alone. "Proliferatives" act to promote tissue repair or growth by prompting release of growth factors, such as cytokines, or increasing the effectiveness of existing circulating growth factors. Prolotherapy has been investigated as a treatment of various etiologies of pain, including arthritis, degenerative disc disease, fibromyalgia, tendinitis, and plantar fasciitis. In all studies the effects of Prolotherapy did not significantly exceed placebo effects. (Dechow, 1999) (Reeves, 2000) (Yelland, 2004) (BlueCross BlueShield, 2006). Per California MTUS guidelines Prolotherapy is not recommended given the lack of medically significant studies; therefore, the request is not medically necessary.