



Notice of Independent Review Decision-WCN

DATE OF REVIEW: 12/24/08

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

20605 Injection of the right lateral epicondylitis and extensor tendon 76986 with ultrasound 77002 and flouroscopy 01992/01991

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

American Boards of Physical Medicine and Rehabilitation and Pain Management

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

- , MD., office visits from 1-30-07 through 5-29-07 (3 visits).
- , MD., office visits from 7-5-07 through 11-24-08 (13 visits).
- 7-26-07 MRI of the right elbow.
- , MD., office visits from 8-15-07 through 12-3-07 (7 visits).
- 8-23-07 , MD., performed a Designated Doctor Evaluation.

- 12-18-07 , MD., performed a Required Medical Evaluation.
- , MD., office visits on 2-25-08 and 10-16-08 (2 visits).
- 9-26-08 , MD., performed a Required Medical Evaluation.

PATIENT CLINICAL HISTORY [SUMMARY]:

On 1-30-07, the claimant presented for evaluation under the direction of , MD. The claimant reported that 2 1/2 months ago, she struck the lateral aspect of her elbow. Since that time, she has been worse. Any sort of activity with that arm hurts. The pain is localized at the region of the lateral humeral epicondyle. On exam, the claimant was tender to palpation over the lateral humeral epicondyle and has reproduction her pain with resisted wrist or MP joint extension. She has full range of motion and is neurovascularly intact. The claimant was provided with a diagnosis of right elbow lateral epicondylitis. The claimant was provided with an injection to the right humeral lateral epicondyle. The claimant was referred to physical therapy for a single visit to learn a home stretching program.

Follow up visits notes the claimant did well post the injection and the therapy session. However, in May 2007, the claimant reported that she pulled open a heavy door and her pain intensified. The symptoms were pretty much the same. On 5-29-07, Dr. provided the claimant with another right elbow lateral epicondyle injection.

Medical records reflect the claimant then came under the care of , MD., on 7-5-07 with complain of right lateral elbow pain. On exam, the claimant had tenderness over the lateral epicondyle and just distal to it, a little bit over the medial epicondyle as well, but mostly on the lateral. The evaluator recommended medications, wrapping, ice and heat. The claimant was taken off work.

Follow-up visits with Dr. noted the claimant was unchanged. Therefore, an MRI was recommended as well as referral to Dr. for evaluation for possible injections.

On 7-26-07, an MRI of the right elbow revealed extensor/lateral epicondylitis.

On 8-2-07, Dr. reported the claimant was better. She was returned to work with restrictions.

On 8-15-07, the claimant was evaluated by , MD. The evaluator reported the claimant had right elbow lateral epicondylitis, severe. The claimant was provided with a prescription for Darvocet N 100. The claimant was also provided with an IM injection of Depo Medrol. He reported that he would hold off on localized injections at this time. Continued conservative treatment would be attempted. The claimant was referred for physical therapy.

On 8-23-07, , MD., performed a Designated Doctor Evaluation. He certified the claimant had reached MMI on this date with 1% whole person impairment based on range of motion loss at the elbow, for a total of 1% upper extremity = 1% whole person.

On 9-19-07, performed a Peer Review regarding continued physical therapy. It was noted the claimant had undergone 9 physical therapy visits and additional visits exceeded ODG recommendations.

On 9-24-07, Dr. recommended an injection into the lateral epicondyle, which was performed. The claimant also continued to follow up with Dr. .

On 10-22-07, Dr. reported the claimant continued to be symptomatic. Recommendations were made for additional physical therapy.

Follow up visits with Dr. noted the continued recommendation for additional physical therapy. The claimant was also provided with medications..

On 11-2-07, Dr. reported the claimant had no neurological deficits. She had pain reproduction on the lateral side of her elbow with all maneuvers, tenderness to palpation, tenderness to palpation, pain with resisted extension of the middle finger, reasonably good ROM, and no muscle atrophy. The claimant was provided with Zanaflex and Darvocet. The claimant was advised on a home therapy program. She was continued at work with restrictions.

Follow up visits with Dr. noted the claimant reported that the medication did not help. She continued to have pain in the elbow, particularly on the lateral side. The claimant asked to be referred to a pain management physician.

On 12-18-07, , MD., performed a Required Medical Evaluation. It was his opinion that treatment to date had been reasonable and medically necessary. He personally felt that the ODG guidelines were a waste of time and effort and totally useless.

Follow up visits with Dr. noted the claimant was continued at work with restrictions. The claimant was also continued on Lortab and with the use of EpiTrain splint.

On 2-25-08, the claimant was evaluated by , MD. The claimant was referred for injection into the lateral epicondyle and extensor. The evaluator reported he would go ahead and schedule injection utilizing x-ray along with ultrasound to identify the area of inflammation and edema. If the claimant does not respond to the injection, then she will be referred back to Dr. for possible surgical solutions.

On 4-10-08 , DO., performed a Peer to Peer. The evaluator did not certify the request for a right lateral epicondyle and extensor injection with x-ray and ultrasound.

Medical records reflect the claimant continued to follow up with Dr. . She was continued off work and with the use of medication to include Lyrica, which did not help. She was continued on Lortab.

On 8-26-08, , DO., performed a UR. The reviewer certified the request for a right lateral epicondyle and extensor tendon, ultrasound and fluoroscopy.

On 9-25-08, the claimant underwent an injection of the lateral epicondyle and extensor under ultrasound.

Medical records reflect the claimant reported 75% pain relief post the injection. However, on 10-16-08 the claimant was noted to have spasms in the forearm. Therefore, Dr. provided the claimant with a prescription for Flexeril. She was also continued with Lortab 5/325. Dr. recommended another injection at the lateral aspect of the right elbow to target one remaining area that is still painful.

On 9-26-08, , MD., performed a Required Medical Evaluation. It was his opinion that ongoing visits were reasonable and necessary. Her problems have not resolved as of this date. She had an injection yesterday and therefore will need follow up. It was the evaluator's opinion that the injection performed was reasonable and necessary. The evaluator reported the claimant needed to have narcotic medication ordered by a pain management specialist. The evaluator felt the claimant had exhausted all treatment that would allow her to have her issues resolved. He felt that there was a lot of psychological overlay symptoms magnification and hysterical personality that led to the point where she is today. The options at this time are severely limited and pain management is probably the best thing for this lady.

On 10-23-08, , DO., performed a Utilization review regarding a lateral epicondylar injection. UR adverse determination. The claimant had good response to a previous injections with minimal residual pain. ODG allows up to one injection because the results are not always sustained, as was the case here.

On 10-28-08 another utilization review was provided by , DO. An adverse determination was provided for a right lateral epicondyle injection and extensor tendon with ultrasound and fluoroscopy.

On 11-24-08, the claimant was evaluated by Dr. . The claimant continued to have tenderness right over her lateral epicondyle on her right elbow. She will return in three months. The claimant is set up for an appeal regarding the adverse determination.

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

BASED ON THE MEDICAL RECORDS PROVIDED, THIS CLAIMANT HAS HAD SEVERAL RIGHT LATERAL EPICONDYLAR INJECTIONS WITHOUT LONG LASTING IMPROVEMENT. ODG-TWC REFLECTS THAT A SINGLE INJECTION CAN BE PROVIDED AS A POSSIBILITY. HOWEVER, BENEFICIAL EFFECTS PERSIST ONLY FOR A SHORT TIME, AND THE LONG-TERM OUTCOME COULD BE POOR. THEREFORE, BASED ON CURRENT EVIDENCE-BASED MEDICINE AND THIS CLAIMANT'S RESPONSE TO PRIOR INJECTIONS, THE REQUEST 20605 INJECTION OF THE RIGHT LATERAL EPICONDYLITIS AND EXTENSOR TENDON 76986 WITH ULTRASOUND 77002 AND FLUOROSCOPY 01992/01991 IS NOT CERTIFIED.

ODG-TWC, last update 12-23-08 Occupational Disorders of the Elbow – Injections:

Recommend single injection as a possibility for short-term pain relief in cases of severe pain from epicondylitis. However, beneficial effects persist only for a short time, and the long-term outcome could be poor. (Boisubert, 2004) The significant short-term benefits of corticosteroid

injection are paradoxically reversed after six weeks, with high recurrence rates, implying that this treatment should be used with caution in the management of tennis elbow. (Bisset, 2006) While there is some benefit in short-term relief of pain, patients requiring multiple corticosteroid injections to alleviate pain have a guarded prognosis for continued nonoperative management. Corticosteroid injection does not provide any long-term clinically significant improvement in the outcome of epicondylitis, and rehabilitation should be the first line of treatment in acute cases, but injections combined with work modification may have benefit. (Assendelft, 1996) (Bowen, 2001) (Reveille, 1997) (AHRQ, 2002) (Newcomer, 2001) (Smidt, 2002) (Stahl, 1997) (Crowther, 2002) (Smidt, 2005) A recent clinical trial of treatments for epicondylitis found that, after 12 months, the success rate for physical therapy (91%) was significantly higher than injection (69%), but only slightly higher than in the wait-and-see group (83%). (Korthals-de Bos, 2004) According to another study, botulinum toxin injection may improve pain over a three-month period in some patients with lateral epicondylitis, but injections may be associated with digit paresis and weakness of finger extension. (Wong, 2005) Steroid injection was associated with an increase in reported pain for the first 24 hours of treatment, but the therapeutic benefits compared with naproxen and placebo were evident 3 to 4 days after the start of treatment. (Lewis, 2005) On the basis of the results of this study, the study authors advocate steroid injection alone as the first line of treatment for patients presenting with tennis elbow demanding a quick return to daily activities. (Tonks, 2007)

Recent research: In this RCT, corticosteroid injection did not affect the apparently self-limited course of lateral elbow pain. One month after injection, DASH (Disabilities of the Arm, Shoulder, and Hand questionnaire) scores averaged 24 versus 27 points (dexamethasone vs placebo), pain 3.7 versus 4.3 cm, and grip strength 83% versus 87%. At 6 months, DASH scores averaged 18 versus 13 points, pain 2.4 versus 1.7 cm, and grip strength 98% versus 97%. In secondary analyses in a subset of patients, perceived disability associated with lateral elbow pain correlated with depression and ineffective coping skills. (Lindenhovius, 2008) In the short-term (< 6 weeks), corticosteroid injection helps relieve symptoms from lateral epicondylitis. After 6 weeks, however, physical therapy is superior to steroid injection for symptom relief (level of evidence, A). Lateral epicondylitis (tennis elbow) can be treated in the short-term (< 6 weeks) with corticosteroid injection, with better improvement vs nonsteroidal anti-inflammatory drugs. After 6 weeks, physical therapy is more efficacious in reducing symptoms vs corticosteroid injection. During initial physical rehabilitation, corticosteroid injections can help control pain from lateral epicondylitis. (Stephens, 2008).

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 KNOWLEDGBASE**
- 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)