



CLAIMS EVAL

*Utilization Review and
Peer Review Services*

CLAIMS EVAL REVIEWER REPORT - WC

DATE OF REVIEW: 8-31-11

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Tendon lengthening, upper arm or elbow, each tendon

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

American Board of Orthopaedic Surgery-Board Certified

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

- 4-29-09 MD., office visit.
- MD., office visits on 9-15-10, 12-1-10, 12-29-10, 1-19-11, 2-9-11, 4-11-11, 6-29-11, and 7-20-11.
- 9-22-10 Utilization Review performed by MD.
- 12-6-10 Utilization Review performed by MD.
- 5-9-11 MD., performed a Utilization Review.
- 7-13-11 Utilization Review performed by DO.
- 8-10-11 Utilization Review performed by DO.

PATIENT CLINICAL HISTORY [SUMMARY]:

On 4-29-09, the claimant was evaluated by MD., with complaints of left and right wrist pain and numbness. She is status post left CTR on 1-15-08. She continues with complaints of right wrist pain and bilateral elbow pain. Her current medications include Neurontin, Tofranil at night and Relafen. The evaluator recommended the claimant continue with her Neurontin and Relafen. He also gave her a trial of Rozerem because she is not sleeping at night. The evaluator reported she is a candidate for right CTR.

9-15-10 MD., the claimant complains of right wrist pain. She states she has carpal tunnel, swelling, numbness, weakness. He reported she had open carpal tunnel surgery 9 months ago. After she had the surgery she went back to work after 4 days. She said her hand did not get better after the surgery. The claimant complains of left elbow pain and left forearm pain with increased weakness and dropping objects. She reports no improvement post surgery. She reports night symptoms and flicking of the hand. She has tried NSAIDs and pain medications with very little progress. She works on the computer a lot. Her medications include Hydrocodone, Naproxen, Dillex-G. On exam, the claimant has positive trigger, and tenderness. There is A-1 pulley tenderness, positive nodule on palpation of tendon, positive edema and decreased range of motion. She has thenar atrophy. Strength is 3/5. Positive elbow medial epicondyle tenderness and edema. There is pain with range of motion, positive Golfers elbow test at the medial epicondyle. There is atrophy, decreased strength 3/5, right

positive lateral epicondyle mild tenderness and edema positive mild tenderness with range of motion. X-rays shows no acute fracture, or dislocations. Assessment Right Golfers elbow, mild right tennis elbow and right IF trigger. Plan: Start Lortab, start Medrol Dosepak, start Daypro. She will undergo physical therapy post steroids. The evaluator requested Brown endoscopic trigger finger release to the right index finger.

9-22-10 Utilization Review performed by MD., for right elbow plasty, arthrotomy, tendon lengthening, platelet injection and shockwave therapy was denied.

12-1-10 MD., the claimant was denied by workers compensation. She has problems sleeping and was given Ambien, which did not work. She wears the brace to work and night time and also one brace for the elbow. She had very little help with oral steroids, splints for tennis/Golfers elbow, NSAIDs, pain medications, muscle relaxer and sleeping aide. The claimant has hand weakness and pain all the time in the forearm, elbow and hand. Physical therapy has been denied as well as surgery. She is ready for surgery and is tired of conservative measures. The evaluator recommended the claimant is to continue with oral steroids, NSAIDs, splints, pain medications, muscle relaxers and sleep aid until surgery is approved. Physical therapy is denied. The claimant was given a prescription for Lortab, Flexeril, start Medrol Dosepak, start Celebrex. The evaluator requested platelet injection, shock wave, z-plasty: right lateral epicondyle, right medial epicondyle. Golfers and Tennis elbow release.

12-6-10 Utilization Review performed by MD., There are no medical records included for review from the surgeon since Sep 2010. There has not been documentation of any conservative care for the elbows. There is no EMG/NCV study demonstrating the presence of carpal tunnel syndrome (CTS). There was recommendation for surgery in September 2010 but no documentation that the patient has failed conservative care for the elbow. There was no injection for the elbow or finger. Platelet Rich Plasma injections are not considered medically necessary per evidence-based guidelines. While there is anecdotal clinical information that this procedure may be helpful for certain orthopaedic conditions, there is a lack of long term peer review studies demonstrating efficacy. There are no long term, randomized, prospective peer review studies regarding this procedure. Therefore, at this time, it is considered investigational and not standard of care. Conclusion/Decision to Not Certify: The request for right brown endoscopic trigger release if, platelet injection, shockwave, z-plasty, right lateral epicondyle and right medial epicondyle, #26989, #20206, #28890, #24305, #24102 is not medically necessary.

12-29-10 MD., the claimant is taking Vicodin every 6 hours and still is not sleeping and in pain. She was wondering what can be done until she is approved to get the surgery. She is still working. The claimant's symptoms are still becoming worse. On exam, the claimant has positive trigger, tenderness, A-1 pulley tenderness, nodule on palpation of the tendon, edema and decreased range of motion. Her strength is 3/5. She has right

old healed scar. She has right thenar atrophy. The claimant has tenderness and edema with pain at the right elbow, medial epicondyle, positive Golfers elbow test at the medial epicondyle with edema, atrophy and decreased strength 2.5. Right positive lateral epicondyle tenderness with edema, tenderness, positive Cozen test, decreased range of motion, edema and decreased strength. The claimant was provided with a right tennis elbow, Golfers elbow and trigger finger on the right. The claimant was continued on Lortab, Flexeril, start Medrol Dosepak and Celebrex.

1-19-11 MD., the claimant reports right hand and elbow pain, numbness, tingling and weakness. WC denied surgery. The claimant has been wearing right elbow brace. The plastic is irritating the skin. The claimant reports right elbow pain with increased weakness and decreased grip strength. The claimant is to continue with oral steroids, NSAIDs, Tennis/Golfers elbow splint, pain medications, muscle relaxers and sleeping aid until surgery is approved. Physical therapy has been denied. The evaluator reported the claimant has loss of strength and atrophy of the right upper extremity compared to the left. She needs surgical intervention to help avoid any permanent damage to the upper extremity from prolonged denial of surgery. If surgery continues to be delayed, the claimant will possibly also have radial tunnel syndrome causing further damage and injury to the right upper extremity. The claimant will be given a steroid injection to the tennis elbow, Golfers elbow and trigger finger and will evaluate in two weeks post injection and if no improvement will request surgery once again. The claimant is continued on Lortab, Flexeril, Medrol Dosepak, and Celebrex.

2-9-11 MD., follow up post injection notes the claimant is given an injection for Hydrocodone, naproxen, Dilex-G, Daypro, Lortab, Flexeril, Medrol Dosepak, Celebrex and Ambien.

4-11-11 MD., the claimant received injections to the right wrist/elbow on 2-9-11. She has noticed discoloration of the skin at wrist and elbow. She has noticed no changes in symptoms. The claimant continues with pain and tenderness. The claimant still has night symptoms and flicking of the hands. She has Tinel's sensation when she accidentally bangs her forearm, just below the wrist. She also has a lot of elbow pain. She really has loss of strength in the hand. She wants surgery. The evaluator reported the claimant has evidence of lateral epicondylitis based on history and physical examination. Recommend tennis elbow release with z-plasty, platelet injection, and shockwave. The patient has clinical evidence of carpal tunnel syndrome and forearm compression of median nerve on zones V & VI based on history and physician examination. Recommend surgical intervention possibly including brown endoscopic CTR/open CTR and forearm decompressive fasciotomy with scope/open., Patient has evidence of trigger finger based on history and physical examination. Recommend trigger release., The following treatment options were discussed in detail with the patient: do nothing; observe; NSAIDs; activity modification; physical therapy; splinting; brace use; oral steroids; open surgery; endoscopic surgery. He discussed in detail the

risks, benefits and alternatives. As part of pre-op planning, we have discussed surgical procedure and associated complications. The claimant agrees with the proposed treatment plan and wishes to proceed.

5-9-11 MD., performed a Utilization Review. the requests for right Brown endoscopic carpal tunnel release, right Brown endoscopic trigger finger trigger release, right lateral epicondylectomy/Z-plasty with platelet injection and shockwave therapy are not medically necessary. The claimant has been treated since 9/2010 for trigger finger, tennis elbow and CTS. The claimant is noted to have right thenar atrophy; but, there are no recent diagnostic studies showing recurrence of CTS. There is no follow-up EMG/NCV study to assess for median nerve function since the surgery. The thenar atrophy is not reversible in many cases. The claimant had CTS that was treated with open CTR in 12/2009. The current atrophy may be due to the chronic CTS that was present prior to the 12/2009 surgery. The revision CTR may not improve current complaints or the atrophy due to the chronicity and severity of the original CTS diagnosis. He recommended an updated nerve test to assess current nerve function. There are notes that stated that 3 injections were possibly performed to the medial and lateral epicondyle and trigger finger. There was no CT injection. This would provide therapeutic effects as well as diagnostic/prognostic information prior to the planned revision CTR. If there is temporary relief then surgery would seem to be reasonable. If there is absolutely no improvement, then surgery is less likely to improve her pathology. The claimant has a history of RSD. Revision CTR and extensive hand, wrist and elbow surgery may lead to recurrence of the RSD. This should be considered in the surgical planning. The use of surgery with platelet injection and shock wave therapy are not considered standard of care for tennis elbow syndrome. While there is anecdotal clinical information that this procedure may be helpful for certain orthopaedic conditions, there is a lack of long term peer review studies demonstrating efficacy of platelet treatment. There are no long term, randomized, prospective peer review studies regarding this procedure. Therefore, at this time, it is considered investigational and not standard of care. There are no prospective peer review studies showing the combined use of these 3 procedures for tennis elbow syndrome.

6-29-11 MD., the claimant has evidence of lateral epicondylitis based on history and physical examination. Recommend tennis elbow release with z-plasty, platelet injection, and shockwave. The patient has clinical evidence of carpal tunnel syndrome and forearm compression of median nerve on zones V & VI based on history and physician examination. Recommend surgical intervention possibly including brown endoscopic CTR/open CTR and forearm decompressive fasciotomy with scope/open., Patient has evidence of trigger finger based on history and physical examination. Recommend trigger release. The claimant was provided with an injection of Marcaine and Kenalog.

7-13-11 Utilization Review performed by DO., notes: Request: right elbow medial/lateral epicondylectomy/Z-p tasty, platelet injection, shockwave treatment

(#24305, #24102, #20605, #28890) Explanation of Findings: The reviewer did not determine the medical necessity of this request based on the available documentation/information and evidence-based guidelines. On 07/12/11 at 3:32 p.m. CT, a phone call was placed to Dr., and he spoke with the operator, who reported the doctor was not available. A message was left about this peer review with a callback number provided. On 07/13/11 at 11:20 a.m. CT, another phone call was placed to Dr., and he spoke with the operator, who reported the doctor was not available. A message was left that recommendation for denial of this request would be done and the non-certification disclaimer was given. The patient is a female who has history of chronic right upper extremity pain with a date of industrial injury on xx/xx/xxxx. According to an EMG/NCV preliminary report study on 04/17/09, there was mention of right carpal tunnel syndrome that was mild to moderate. In an orthopedic note on 09/15/10, there was mention that the patient had open carpal tunnel surgery nine months prior and that there was mention that the patient did not get any better after that surgery. In an orthopedic clinic note on 06/29/11, there was mention that the patient continued to have the right upper extremity pain with right tennis elbow and right ring finger and thumb trigger finger along with night symptoms and flicking of the hands, and it was thought that the patient had recurrent carpal tunnel syndrome on the right causing numbness and tingling and hand pain along with mention that the patient received several steroid injections for the tennis elbow, trigger finger right ring finger and thumb but the pain issues have continued along with mention that the patient was on multiple medication management for pain. Also per the 06/29/11 note, there was mention that there was positive nerve compression in the right hand; Tinel's was positive at the wrist; there was a positive Durkin's/compression symptoms at the wrist; positive Phalen's, positive thenar atrophy, decreased ability to oppose the thumb, positive forearm Tinel's sign in zones 5 and 6; positive forearm compression in zones 5 and 6, positive forearm tenderness in zones 5 and 6, positive trigger finger in the right ring finger and thumb along with tenderness and A-1 Pulley tenderness; positive nodule on palpation of the tendon, positive edema, decreased range of motion, positive deformity, healed open carpal tunnel scar in the right hand, positive lateral epicondyle tenderness in the right elbow along with edema and tenderness with range of motion, positive Cozen's test lateral epicondyle, decreased range of motion, positive edema, positive atrophy, decreased strength at 3/5, and white pigmentation due to steroid on the right lateral elbow, right wrist and right ring finger, with listed diagnoses of carpal tunnel syndrome, tennis elbow and trigger finger and surgery was recommended for the elbow and wrist region as well as the elbow brace. Also per the 06/29/11 note, there was mention that the patient was to continue conservative measures including medications, splinting and oral steroids, until surgery was approved along with the multiple medication management for pain. He noted it is also not clear as to why both the shockwave treatment and the surgery will be requested at the same time as opposed to doing one versus the other. It is not clear specifically as to why the right elbow medial and lateral epicondyle are being requested for the surgery as there was mention that only the lateral epicondyle has been affected and no mention of any specific or significant

problem occurring at the medial epicondyle. Also, it is not clear specifically as to whether appropriate physical therapy or instruction in home exercise was done for the elbow region as there was no mention of any particular documented physical therapy treatment for the right elbow and focusing on the lateral epicondyle region. Also, surgery for epicondylitis may not necessarily improve the patient's overall condition and is still considered under study in the guideline criteria. Therefore, the right elbow medial/lateral epicondylectomy/Z-plasty, platelet injection, shockwave treatment (#24305, #24102, #20605 and #28890) cannot be recommended for approval.

7-20-11 MD., the claimant is post injection/elbow brace, right elbow continues to have swelling, swelling DJD subside with brace. She does continue to have pain at the elbow, pain does radiate up/down the arm. She has throbbing, tingling with sensitivity to touch, especially with extension/flexion motion. The claimant has some improvement of the thumb and elbow after steroid injection, splints, NSAIDS, pain medications, muscle relaxers, and sleeping aid, the claimant continues with pain and tenderness. The claimant with right tennis elbow and right RF thumb trigger. The claimant with night symptoms and flicking of the hands. Right recurrent CTS causing numbness/tingling and hand pain. The claimant has received several steroid injection about 4 for the tennis elbow, trigger finger right RF thumb and CTS to the point that she has white pigmentation to the areas. The claimant needs surgery but has been denied. The evaluator reported the claimant has evidence of lateral epicondylitis based on history and physical examination. Recommend tennis elbow release with z-plasty, platelet injection, and shockwave. The patient has clinical evidence of carpal tunnel syndrome and forearm compression of median nerve on zones V & VI based on history and physician examination. Recommend surgical intervention possibly including brown endoscopic CTR/open CTR and forearm, decompressive fasciotomy with scope/open., Patient has evidence of trigger finger based on history and physical examination. Recommend trigger release. Surgery Ordered Anesthesia : general no Medical Clearance needed Brown Procedure (Endoscopic Carpal Tunnel Release) : Right BETR (Brown Endoscopic Trigger Finger Release) : Right Ring finger and open R thumb trigger release, Platelet injection, Shock wave, z-plasty : Right lateral epicondyle.

8-10-11 Utilization Review performed by DO., notes the request is for right elbow medial/lateral epicondylectomy/ Z-plasty, platelet injection, and shockwave treatment (24305, 24102, 20605, and 28890) Explanation of Findings: First it should be noted that according to Dr, the request for the elbow surgery was submitted incorrectly and he would resubmit the request for the correct procedure. The evaluator was able to determine the medial necessity of this modified request based on available documentation/information and evidence-based guidelines. First it should be noted that according to Dr., the request for the elbow surgery was submitted incorrectly and he would resubmit the request for the correct procedure. According to the Official Disability Guidelines regarding surgery for epicondylitis, "Under study, almost all patients respond to conservative measures and do not require surgical intervention. Treatment involves

rest, ice, and stretching, strengthening, and lower intensity to allow for maladaptive change. Any activity that hurts on extending or pronating the wrist should be avoided. With healing, strengthening exercises are recommended. Patients, who are recalcitrant to six months of conservative therapy, including corticosteroid injections, may be candidates for surgery." According to the Official Disability Guidelines regarding platelet injections, "Under study, further evaluation further of this novel treatment is warranted. Rigorous studies of sufficient size samples, assessing these injection therapies using validated clinical, radiological, and biomechanical measures, and tissue injury/healing responsive biomarkers, are needed to determine long-term effectiveness and safety, and whether these techniques can play a definitive role in the management of lateral epicondylitis and other tendinopathy." Therefore, at this point, it is considered investigational. Also, according to the Official Disability Guidelines regarding extracorporeal shockwave therapy, "Not recommended, trials in this area have yielded conflicting results. The value, if any, of ESWT for lateral elbow pain, can presently be neither confirmed nor excluded. After other treatments have failed, some providers believe that shock-wave therapy may help some people with heel pain and tennis elbow. However, recent studies do not always support this, and ESWT cannot be recommended at this time for epicondylitis, although it has very few side effects." With regard to the purchase of brace L3702 Elbow Air-form Tennis Brace for the right elbow, the Official Disability Guidelines states, "Recommended for cubital tunnel syndrome including a splint of foam elbow pad worn at night and/or elbow pad, and under study for epicondylitis. No definitive conclusions can be drawn concerning effectiveness of standard braces or splints for lateral epicondylitis. If used, bracing or splinting is recommended only as a short-term initial treatment for lateral epicondylitis in combination with physical therapy." As the brace is intended for post-operative use, it would not be warranted at this point. With regard to the right brown endoscopic index trigger finger release, the Official Disability Guidelines states, "Recommended where symptoms persist. Trigger finger is a condition in which the finger becomes locked in a bent position because of an inflamed and swollen tendon. In cases where symptoms persist after steroid injection, surgery may be recommended." There was mention that the patient has had multiple injections for the trigger finger with continued complaints of pain and dysfunction. Therefore, a modified request for right brown endoscopic index trigger finger release #26989 is medical necessity and reasonable and can be recommended.

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

BASED ON THE RECORDS PROVIDED, THE TENDON LENGTHENING, UPPER ARM OR ELBOW, EACH TENDON IS REASONABLE SINCE SHE HAS FAILED INJECTIONS FOR LATERAL EPICONDYLITIS. MEDICAL RECORDS REFLECT

THAT MOST PATIENTS RESPOND TO CONSERVATIVE MEASURES AND DO NOT REQUIRE SURGICAL INTERVENTION. HOWEVER, THIS CLAIMANT HAS FAILED ALL FORMS OF CONSERVATIVE TREATMENT. THEREFORE, SURGERY IS THE OPTION LEFT. THEREFORE, THE TENDON LENGTHENING, UPPER ARM OR ELBOW, EACH TENDON IS REASONABLE AND MEDICALLY NECESSARY.

ODG-TWC, last update 5-26-11 Occupational Disorders of the Elbow: Surgery for epicondylitis: Under study. Almost all patients respond to conservative measures and do not require surgical intervention. Treatment involves rest, ice, stretching, strengthening, and lower intensity to allow for maladaptive change. Any activity that hurts on extending or pronating the wrist should be avoided. With healing, strengthening exercises are recommended. Patients who are recalcitrant to six months of conservative therapy (including corticosteroid injections) may be candidates for surgery. There currently are no published controlled trials of surgery for lateral elbow pain. Without a control, it is impossible to draw conclusions about the value of surgery. Generally, surgical intervention may be considered when other treatment fails, but over 95% of patients with tennis elbow can be treated without surgery. (Buchbinder-Cochrane, 2002) (California, 1997) (Piligian, 2000) (Foley, 1993) (AHRQ, 2002) (Theis, 2004) (Jerosch, 2005) (Balk, 2005) (Sennoune, 2005) (Szabo, 2006) Disappointing results of surgery were found in litigants with epicondylitis. (Kay, 2003) (Balk, 2005) Surgery is not very common for this condition. In workers' compensation, surgery is performed in only about 5% cases. (WLDI, 2007) For the minority of people with lateral epicondylitis who do not respond to nonoperative treatment, surgical intervention is an option. The surgical techniques for treating lateral epicondylitis can be grouped into three main categories: open, percutaneous, and arthroscopic. Although there are advantages and disadvantages to each procedure, no technique appears superior by any measure. Therefore, until more randomized, controlled trials are done, it is reasonable to defer to individual surgeons regarding experience and ease of procedure. (Lo, 2007)

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)