

True Resolutions Inc.

An Independent Review Organization
500 E. 4th St., PMB 352
Austin, TX 78701
Phone: (214) 717-4260
Fax: (214) 276-1904
Email: rm@trueresolutionsinc.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES:

Oct/08/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Right Elbow Injection

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

Board Certified Orthopedic Surgeon (Joint)

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 medical necessity exists for each health care service in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines
Clinical notes 05/09/13-07/29/13
Therapy notes 05/09/13-06/03/13
Adverse determinations 08/02/13 and 08/30/13

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a female who reported an injury to her right elbow. Clinical note dated 05/09/13 indicated the patient was lifting a piece of luggage when she felt a sharp pull on the right forearm. The patient rated her pain as 8/10. Pain radiated to the right distal portion of the forearm. Upon exam localized tenderness was moderate at the lateral epicondyle radiating into the forearm, brachial, and brachioradialis. No neurological deficits were noted. The patient demonstrated full range of motion throughout the right upper extremity. The patient was subsequently diagnosed with lateral epicondylitis. Clinical note dated 05/16/13 indicated the patient wearing elbow support with no significant improvement in symptoms. The patient was provided with a trigger point injection at this time. The patient was recommended to initiate physical therapy at this time. Clinical note dated 05/23/13 indicated the patient continuing a pattern of symptoms slowly improving at the right elbow. The patient was utilizing a Velcro tennis elbow strap at this time. Therapy note dated 06/03/13 indicated the patient completing eight physical therapy sessions to date. Clinical note dated 06/10/13 mentioned the patient continuing with lateral epicondyle pain. The patient demonstrated 5-130 degrees of range of motion at the right elbow. X-rays revealed a coronoid spur with otherwise normal findings. Clinical note dated 07/29/13 indicated the patient completing nine

physical therapy visits. The patient was utilizing Naprosyn. The patient was undergoing home exercise program at this time. Utilization review dated 08/02/13 resulted in denial for right elbow injection as the request included CPT code 20610 which was indicative of injection at a major joint and bursa which was not consistent with an elbow injection. Utilization review dated 08/30/13 resulted in denial for right elbow injection as injections were not recommended as a routine intervention for epicondylitis.

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

Clinical documentation submitted for review notes the patient complaining of right elbow pain with associated range of motion deficits. Currently, no high quality studies exist supporting the use of injection therapy at the elbow for the specific complaints of epicondylitis. Recent studies revealed that ongoing physical therapy beyond six weeks have been found to be superior to steroid injections for symptomatic relief. Given this, the request is not indicated. As such it is the opinion of this reviewer that the request for right elbow injection is not recommended as medically necessary.

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

- ACOEM-AMERICA 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)