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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Sep/10/2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: left elbow lateral epicondylar debridement common extensor repair

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: M.D., Board Certified Orthopedic Surgeon

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. It is the opinion of this reviewer that the request for left elbow lateral epicondylar debridement common extensor repair is not recommended as medically necessary

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a male who reported injury to his left upper extremity. A clinical note dated 06/06/13 indicated the patient experienced a pulling sensation at the left elbow. Date of injury was xx/xx/xx. Upon exam, the patient demonstrated full range of motion with no strength deficits at the left elbow. X-rays of the left elbow revealed no fracture or dislocation. Swelling was moderate at the lateral side. The operative report dated 01/27/14 indicated the patient undergoing left forearm/elbow injection. A clinical note dated 04/09/14 indicated the patient continuing left forearm and elbow symptoms consistent with lateral epicondylitis. The patient stated that all activities exacerbated his pain. The patient attended physical therapy and utilized ibuprofen for pain relief. A clinical note dated 05/09/14 indicated the patient complaining of numbness and tingling at left third and fourth fingers. Tenderness to palpation was identified at the elbow. The patient stated he was having difficulty rotating steering wheel of his car. The MRI of the left elbow dated 05/13/14 indicated the patient revealing signs consistent with lateral epicondylitis and possible partial tear at the common extensor tendon. Signal was increased within the supinator muscle. Clinical note dated 06/17/14 indicated the patient being recommended for lateral epicondylectomy. The utilization review dated 06/22/14 resulted in denial as no information was submitted confirming full course of conservative treatment. The utilization review dated 08/08/14 resulted in denial as insufficient information was submitted confirming clinical status indicating appropriateness of the proposed procedure.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: he patient complained of ongoing left elbow pain and had confirmation of lateral epicondylitis by MRI. However, no information was submitted regarding completion of a full 12 month course of conservative treatment. The patient initiated therapy however no therapy notes were submitted for review confirming

completion of a full course of treatment. Without this information in place it is unclear if the patient would benefit from the proposed surgical procedure. Therefore this request is not indicated. As such, it is the opinion of this reviewer that the request for left elbow lateral epicondylar debridement common extensor repair is not recommended as medically necessary and the prior denials are upheld.

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)