INDEPENDENT REVIEWERS OF TEXAS, INC.

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Notice of Independent Review Decision

[Date notice sent to all parties]:

10/14/2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: cortisone injections

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

Board Certified Orthopedic Surgeon

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

☒ Upheld (Agree)

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a female who reported an injury to her left elbow as a result of her work related incident. The clinical note dated 08/08/14 indicated the patient complaining of ongoing left lateral elbow pain radiating to the left index finger. The patient reported a six month course of symptoms. The patient described the pain as a dull and aching sensation specifically over the lateral portion of the left elbow. Lifting and pushing objects exacerbated pain level. A clinical note dated 08/22/14 indicated the patient previously undergoing two elbow injections. The patient

utilized tennis elbow strap. Upon exam tenderness was identified at the extensor origin. The patient was recommended for cortisone injection. The utilization reviews dated 08/18/14 and 09/04/14 resulted in denials as insufficient information was submitted regarding completion of any conservative treatment and evidence based guidelines do not recommend cortisone injections as an intervention for epicondylitis.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:
The patient complained of lateral left elbow pain. Currently no high quality studies exist supporting the use of injections to address lateral epicondylitis. Without supporting evidence in place regarding the safety and efficacy of the proposed procedure this request is not indicated. As such, it is the opinion of this reviewer that the request for cortisone injection at the left elbow is not recommended as medically necessary.

IRO REVIEWER REPORT TEMPLATE -WC

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

[X] MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

[X] ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

Injections (corticosteroid)

Not recommended as a routine intervention for epicondylitis, based on recent research. In the past a single injection was suggested as a possibility for short-term pain relief in cases of severe pain from epicondylitis, but beneficial effects persist only for a short time, and the long-term outcome could be poor. (Boisaubert, 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 corticosteriod 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) Long-term use of corticosteroid injections for tendinopathy may be harmful, according to the results of a systematic review of randomized controlled trials reported in The Lancet. There was moderate evidence of harmful effects of repeated corticosteroid injection on pain, but the optimal number of doses and interval between injections are not known. The authors urged patients and practitioners to consider results of corticosteroid treatment that might not be defined as adverse, including negative long-term outcomes and high recurrence rates. The evidence for specific exercise therapy is more encouraging than the evidence for corticosteroid injection, and exercise therapy is likely to promote protein synthesis via cell signalling. Specific exercise therapy might produce more cures at 6 and 12 months than one or more corticosteroid injections. (Coombes, 2010) An RCT comparing corticosteroid injection to corticosteroid iontophoresis for lateral epicondylitis found that the iontophoresis patients had statistically significant improvement in grip strength, and they were also more likely to get back to work without restriction. However, by six-month follow-up, all groups had equivalent results for all measured outcomes. (Stefanou, 2012) This RCT found that patients treated with a single corticosteroid injection had a 14% greater chance of poor outcome and a 77% increased risk for reinjury at 1 year relative to placebo. Physical therapy did improve short-term pain and disability outcomes, although those benefits were lost when steroid injection was added to the treatment. Lateral epicondylitis is not an inflammatory condition, and steroid shots work best when inflammation is the problem, and even then they usually provide only temporary relief at best. Use of steroid injections to treat tennis elbow has been increasingly discouraged because of lack of long-term efficacy data and high recurrence rates. (Coombes, 2013) See also Iontophoresis; Hyaluronic acid injections; Viscosupplementation; Prolotherapy; Autologous blood injection; Platelet-rich plasma (PRP); & Botulinum toxin injection.