

AccuReview

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Notice of Independent Review Decision

[Date notice sent to all parties]: February 10, 2015

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

1 Ultrasound guided percutaneous tenotomy with open debridement (left lateral epicondyle) for the left elbow as an outpatient

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

This physician is Board Certified in Orthopaedic Surgery with over 14 years of experience.

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 claimant is a right-hand dominant male who presents with complaints of left elbow pain. He felt a pop in the lateral aspect of his elbow. He has had pain and weakness in the elbow since that time, which was some time in October 2013. He has had treatment with naproxen, an elbow strap, and work restrictions but has had no real improvement with symptoms. He stated that he cannot really do his job secondary to pain at this time.

01-08-14: MRI Elbow Without Contrast LT/ADD15MIN. Impression: 1. Findings compatible with lateral epicondylitis with associated partial-thickness tear of the common extensor tendon as discussed. 2. Minimal subchondral edema of the radial head as discussed. 3. Small joint effusion.

01-30-14: History & Physical. CC: elbow pain, left elbow for 2 ½ months after repeatedly hitting an object at work. Assessment & Plan: Epicondylitis, lateral 726.32. PE: Orthopedic: Examination of his left elbow revealed tenderness over the lateral epicondyle. He has full ROM in flexion, extension, pronation and supination. He has pain with resisted wrist and middle finger extension. He has a 2+ radial pulse. Interpretation of Radiograph: MRI revealed a partial-thickness tear of the common extensor tendon with surrounding edema. Assessment: left elbow common extensor partial-thickness tear. Recommendations: The claimant is probably not going to improve with conservative treatment and will require lateral epicondyle debridement and common extensor tendon repair. The other option is to continue conservative treatment. Recommend surgery.

03-03-14: Operative Report. Preoperative Diagnosis: Left elbow lateral epicondylitis. Postoperative Diagnosis: same. Procedure: Left elbow lateral epicondyle debridement, extensor tendon repair.

03-13-14: History & Physical. Claimant is 10 days post-op. Current medications: Norco 5/325 1-2 tabs Q4-6hrs PRN pain. Assessment & Plan: Epicondylitis, lateral 726.32. PE: Examination revealed that the incision is healing nicely with no erythema or drainage. He has full ROM lacking about 10 degrees of full extension. Assessment: status post the above. Plan: filled work comp and set him up with therapy, return in 4 weeks.

04-17-14: History & Physical. CC: left elbow pain. PE: examination revealed a well-healed surgical scar with some tenderness over it. Swelling has decreased and noted full motion of the elbow. Assessment: S/P left elbow epicondyle debridement and common extensor tendon repair, Recommend continued therapy and continued off work, return in 6 weeks.

06-12-14: History & Physical. Claimant stated that his left elbow pain feels better but is still painful and concerned. PE: well-healed surgical scar with some tenderness just proximal to the incision. Full ROM. Assessment: S/P lateral epicondyle debridement and extensor tendon repair. Recommendations: Due to the fact that claimant is still having significant pain, will re-do the MRI and make certain that this area has not been re-torn. Start anti-inflammatory.

07-08-14: History & Physical. Claimant is following up for his left elbow lateral epicondyle debridement and common extensor tendon repair. MRI revealed some diffuse signal alteration along the common extensor tendon and humeral attachment which is artifact consistent with anchor placement and a small amount of fluid just deep to the tendon measuring approximately 8 x 4 mm but no evidence of a full-thickness tendon tear. Assessment: continued irritation status post lateral epicondyle debridement and common extensor tendon repair. Recommendations: Tendon appears intact. Would not recommend any further surgery. Continue anti-inflammatories for 6 weeks and reassess.

09-02-14: History & Physical. CC: elbow pain. Current medications: Mobic 15mg PO daily. Claimant has not been back to work due to continued pain. He

stated he is occasionally taking anti-inflammatory for pain; however, he is not taking anything scheduled. PE: left upper extremity has well-healed surgical incision over the lateral epicondyle with no erythema or other signs of infection. He is point tender directly over the lateral epicondyle, passive pronation and supination while flexing and extending the elbow is negative for any popping or signs of plica. Pain noted with active extension of his wrist in both 90 degrees flexion and full extension. He does have a mildly positive tennis elbow shear test. ROM is 10 degrees to 135 degrees. Interpretation of Radiographs: MRI of the left elbow was review again, which showed some fluid under the common extensor tendon and likely some postsurgical changes. Assessment/Plan: continued left elbow pain s/p open debridement of left common extensor group. At this time, there is no findings of posterolateral rotary instability, plica, or anything that would state he is having some trouble from the osteochondral defect seen on his radial head as he has no pain with passive and active pronation and supination. Recommend continued conservative management at this time. Ibuprofen script given for TID with meals and scheduled to decrease some inflammation and avoid activated that cause discomfort, continued work excuse. Placed in a splint, follow up in 3 months.

12-05-14: Miscellaneous Transcription. Claimant has significant pain and stated that it is directly over the left lateral epicondyle even though he has been diligent with his stretching exercises and continued pain. PE: Tenderness noted directly over the left lateral epicondyle and stated significant pain with wrist extension with the elbow extended and has a positive laptop test. Assessment/Plan: Claimant has continued s/s of left lateral epicondylitis s/p open debridement. Recommend left lateral epicondyle percutaneous tenotomy with ultrasound examination.

12-16-14: UR. Reason for denial: Recommend prospective request for 1 Ultrasound guided percutaneous tenotomy with open debridement (left lateral epicondyle) for left elbow as an outpatient between 12/12/2014 and 1/26/2015 be non-certified. This is a male who was injured on xx/xx/xx. The most recent progress note is dated December 5, 2014 and is dated to be nine months s/p debridement of the left lateral epicondyle. There are complaints of continued pain at this site. The injured employee has been participating in a HEP with stretching. The physical examination revealed no erythema or signs of infection. There was tenderness directly over the left lateral epicondyle and pain with wrist extension and elbow extension. There was a positive laptop test. The injured employee had full ROM of the elbow and was neurovascularly intact. 12/12/14 attempted to speak with the requesting physician, unsuccessful.

12-18-14: Letter of Reconsideration. Claimant is experiencing persistent left lateral epicondylitis and pain after his open procedure over 9 months ago. He has participated in PT, eccentric stretches and isometric strengthening exercises, HEP, anti-inflammatories, and bracing. Despite all of these modalities, he continued to have s/s and pain as in the initial meeting. The claimant is warranted a repeat procedure to address his lateral epicondylitis. Recent literature, including a prospective study published in the The New England Journal of Medicine, has questioned the effectiveness for steroid injections for lateral epicondylitis and in

fact, it has actually been shown to decrease the effectiveness of operative procedures for those patients that fail conservative treatment with the bracing and the therapy exercises. Therefore, we did not choose to do an injection.

12-31-14: UR. Reason for denial: Recommend prospective request for 1 Ultrasound guided percutaneous tenotomy with open debridement (left lateral epicondyle) for left elbow as an outpatient between 12/12/2014 and 1/26/2015 be non-certified. The claimant is a male who sustained an injury to the elbow on xx/xx/xx. The claimant was diagnosed with lateral epicondylitis of elbow, stiffness of joint, not elsewhere classified, forearm, and pain in joint, forearm. There was also mention of surgeries including left eye, left foot, and knee arthroscopy. The claimant was operated on 3/3/14 for left elbow lateral epicondyle debridement and extensor tendon repair. The MRI of the left elbow findings dated 6/26/14 revealed small osteochondral involving the radial head, diffuse signal alteration involving the common extensor tendon at the humeral attachment with susceptibility artifact, consistent with an anchor placement, a small amount of fluid just deep to the tendon measuring approximately 8x4mm, moderate sized joint effusion within the elbow and surgery and hardware placement. The claimant was evaluated on 12/5/14 with a chief complaint of left elbow pain. The claimant stated that he had continued significant pain directly over the left lateral epicondyle. The PE findings revealed tenderness directly over the left lateral epicondyle, significant pain with wrist extension with elbow extended, and positive laptop test. And there were no other significant findings noted. The treatment plan includes left lateral epicondyle percutaneous tenotomy with ultrasound examination. The letter addressing the previous denial has been reviewed. In the letter it specifically stated that despite conservative measures after the claimant had undergone surgery to the elbow, the claimant continued to suffer from symptoms of lateral epicondylitis. The denial letter specifically stated that the ultrasound guided tenotomy is being requested. I do agree that a repeat procedure after many months of conservative treatment after initial procedure is warranted. However, there would be no need for an ultrasound guided tenotomy and an open debridement. The denial letter only addresses the ultrasound guided tenotomy.

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

The request for left elbow lateral epicondyle ultrasound guided tenotomy and open debridement is denied. The claimant underwent open debridement and repair of the extensor tendon of the left elbow in March 2014. A postoperative June 2014 MRI demonstrated persistent tendonitis of the common extensor origin. The claimant has failed a course of extensive postoperative care. The claimant may require additional surgery to the elbow, as he remains symptomatic. The most recent MRI of the elbow is over six months old. An up-to-date MRI is required to determine the current condition of the common extensor tendon. A current MRI would determine whether the claimant requires additional surgery. The tendon may require further debridement and possible repair. Based on the records reviewed, it is unclear why the patient requires an ultrasound-guided tenotomy as well as an open procedure. An open procedure is usually recommended for a revision surgery. The proposed procedure is not medically

necessary for this patient at the present time. Therefore, after reviewing the medical records and documentation provided, the request for 1 Ultrasound guided percutaneous tenotomy with open debridement (left lateral epicondyle) for the left elbow as an outpatient is non-certified.

Per ODG:

Surgery for epicondylitis	Criteria for Lateral Epicondylar Release for Chronic Lateral Epicondylalgia: - Limit to severe entrapment neuropathies, over 95% recover with conservative treatment - 12 months of compliance with non-operative management: - Failure to improve with NSAIDs, elbow bands/straps, activity modification, and PT exercise programs to increase range of motion and strength of the musculature around the elbow. - Long-term failure with at least one type of injection, ideally with documented short-term relief from the injection. - Any of the three main surgical approaches are acceptable (open, percutaneous and arthroscopic).
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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)