Core 400 LLC

An Independent Review Organization
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Description of the service or services in dispute:
Surgery to repair medial epicondyle of right elbow. 24359 - Under Repair, Revision, and/or Reconstruction Procedures on the Humerus (Upper Arm) and Elbow

Description of the qualifications for each physician or other health care provider who reviewed the decision: Board Certified Orthopedic Surgeon

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

☐ Overturned (Disagree)
☑ Upheld (Agree)
☐ Partially Overturned (Agree in part / Disagree in part)

Patient Clinical History (Summary)

XXXX, right-hand-dominant XXXX who was diagnosed with medial epicondylitis, right elbow (M77.01). XXXX. On XXXX, XXXX was XXXX and sustained a strain / sprain to the right arm and elbow.

On XXXX, XXXX was evaluated by XXXX for right elbow pain, which had begun approximately four to five days prior. XXXX reported the symptoms began while XXXX. XXXX rated the pain at 2-8/10 depending on activity. XXXX also reported numbness, swelling, and stiffness. XXXX had injections and an MRI done and presented to discuss other treatment options. XXXX medication list included XXXX. On examination of the elbow, there was point tenderness over the medial epicondyle and pain with resisted pronation and wrist flexion. X-rays of the right elbow were unremarkable. The MRI findings were consistent with medial tendon tear of the elbow. XXXX diagnosed medial epicondylitis of the right elbow, assessed that XXXX symptoms had become intractable, and planned to proceed with medial epicondyle repair.

An MRI of the right elbow dated XXXX, revealed partial proximal tearing of the common flexor tendon. There were findings of acute-upon-chronic tendonitis of the common extensor tendon. Focal radiocapitellar osteoarthritis was seen.

Treatment to date consisted of medications (XXXX) and injections.

Per a utilization review determination letter by XXXX, dated XXXX, the request for outpatient right medial epicondyle repair to include CPT code 24359 was not certified. It was determined that the guidelines would not support surgery for epicondylitis, unless there was objective

documentation of failure of 12 months of lower levels of care. The injury occurred in XXXX. A prior injection was performed, but response was not noted. There was no substantial functional limitation or difficulties with activities of daily living documented to support the necessity for surgery prior to exhaustion of lower levels of care. Failure of oral medication, activity modification, strapping, formal physical therapy, and a home exercise program were not noted, hence the request for a right medial epicondyle repair was not certified.

A utilization review determination letter by XXXX indicated that the reconsideration request was denied. The request was previously noncertified due to lack of 12 months of conservative care to include the response to the prior injection and the lack of substantial functional limitations or difficulties with activities of daily living. No additional documentation was submitted. The previous non-certification was supported. The guidelines required 12 months of conservative care. The injury occurred in XXXX, and there had not been 12 months of conservative care, to include NSAIDs, elbow band / strap, activity modification, and physical therapy. There was no documentation of substantial functional limitations on physical examination. The case was discussed with XXXX. Although XXXX was said to have a history of being treated, there were no records of continuous treatment of lower levels of care, as per the guidelines. The reconsideration request for outpatient, right medial epicondyle repair to include CPT code 24359 was not certified.

Analysis and Explanation of the Decision include Clinical Basis, Findings and Conclusions used to support the decision.

The ODG recommends surgery for medial epicondylitis following 12 months of compliance with nonoperative management including NSAIDs, elbow band/straps, activity modification and physical therapy exercise programs. The provided documentation reveals imaging findings consistent with medial epicondylitis. A clinical progress note from XXXX suggest that the previous treatment has included injections, but the treatment response is not documented. There is no documentation of other conservative treatments. Surgery to include a medial epicondyle repair was recommended in the note from XXXX. Given the fact that surgery was recommended approximately six weeks out from injury and there is a lack of documented conservative treatment, the proposed medial epicondyle repair would not be considered 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 and Environmental Medicine
- ☐ AHRQ-Agency for Healthcare Research and Quality Guidelines
- ☐ DWC-Division of Workers Compensation Policies and Guidelines
- ☐ European Guidelines for Management of Chronic Low Back Pain
- ☐ Interqual Criteria
- ☑ Medical Judgment, Clinical Experience, and expertise in accordance with accepted medical standards
- ☐ Mercy Center Consensus Conference Guidelines
- ☐ Milliman Care Guidelines
- ☑ ODG-Official Disability Guidelines and Treatment Guidelines
  ODG, 2018: Elbow
  Surgery for epicondylitis

Recommended for chronic lateral or medial epicondylitis as indicated below, after 12 months of failed conservative treatment.
For possibly recommended initial conservative epicondylitis treatments, see Acupuncture; Autologous blood injection; Exercise; Injections (corticosteroid); Iontophoresis; Laser treatment (LLLT); Manipulation; NSAIDs; Physical therapy; Platelet-rich plasma (PRP); Prolotherapy; Stretching; Tennis elbow band; Topical NSAIDs; Ultrasound, therapeutic; Viscosupplementation.

Criteria for Epicondylar Release for Chronic Epicondylalgia:
- Limit to persistent symptoms that interfere with activities that have not responded to an appropriate period of nonsurgical treatment, 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.
- Any of three lateral surgical approaches are acceptable (open, percutaneous and arthroscopic); open approach for medial.

- ☐ Pressley Reed, the Medical Disability Advisor
- ☐ Texas Guidelines for Chiropractic Quality Assurance and 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)

Appeal Information

You have the right to appeal this IRO decision by requesting a Texas Department of Insurance, Division of Workers' Compensation (Division) Contested Case Hearing (CCH). A Division CCH can be requested by filing a written appeal with the Division's Chief Clerk no later than 20 days after the date the IRO decision is sent to the appealing party and must be filed in the form and manner required by the Division.

Request for or a Division CCH must be in writing and sent to:
Chief Clerk of Proceedings Texas Department of Insurance
Division of Workers' Compensation P. O. Box 17787
Austin, Texas, 78744

For questions regarding the appeals process, please contact the Chief Clerk of Proceedings at 512-804-4075 or 512- 804-4010. You may also contact the Division Field Office nearest you at 1-800-252-7031.