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**April 3, 2018**      **Amended: May 4, 2018**  
**IRO CASE #: XXXXXX**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**

Medial epicondyle injection

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

Pain Management Physician

**REVIEW OUTCOME:**

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

X Overturned                      (Disagree)

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 XX who was injured on XXXX. The patient was XX. The patient XX right knee and hand. The XX left leg and XX left arm and hand.

On XXXX, the patient underwent physical therapy (PT) evaluation at XX. The patient was diagnosed with sprain of ligaments of the lumbar spine, contusion of the right knee, strain of muscle, fascia and tendon at wrist and hand level, left hand; and contusion of the left thigh. The patient was recommended therapy XX.

On XXXX, the patient attended PT session at XX consisting of manual therapy, therapeutic exercises and neuromuscular re-education.

On XXXX, XX, evaluated the patient for pain in the knee, back, hip, elbow and neck. The left wrist complaints had remained the same. The pain was rated at 6/10. The grip strength had increased. The lumbar spine complaints had decreased and range of motion (ROM) had increased. The right knee had increased ROM, decreased tenderness and normal gait. The pain had decreased. The pain level was 4. The left knee ROM and gait had returned to normal. The pain level was 0. An examination of the left wrist showed increased grip strength. An examination of the lumbar spine showed normal gait and ROM but negative straight leg raise (SLR) test. XX reviewed x-rays of the left hand/wrist, lumbar spine, right knee and left knee dated XXXX, all of which were negative. XX diagnosed sprain of ligaments of the lumbar spine, contusion of the right knee, strain of muscle, fascia and tendon at wrist and hand level, left hand; and contusion of the left thigh. XX continued Lodine and Flexeril, recommended application of ice and continued PT. The patient was recommended restricted duty.

On XXXX, the patient underwent PT re-evaluation at XX and was recommended XX sessions of PT.

On XXXX, the patient attended XX session of PT consisting of manual therapy and neuromuscular reeducation.

On XXXX, XX noted the left elbow was painful and the patient had problem turning XX hand/palm up. The left elbow pain was rated at 6/10. The strength had decreased. The left wrist complaints had remained the same. The lumbar spine complaints had decreased. On exam, the left elbow had full ROM. There was tenderness in the medial epicondyle and the supination and pronation had decreased. XX diagnosed sprain of ligaments of the lumbar spine, contusion of the right knee, strain of muscle, fascia and tendon at wrist and hand level, left hand; left thigh contusion and pain in the left elbow. XX prescribed XX and continued PT.

On XXXX, PT/OT preauthorization request form was documented.

On XXXX, a magnetic resonance imaging (MRI) of the left elbow performed at XX and read by XX. The study showed a small to moderately sized elbow joint effusion and 6 mm in length partial thickness tear of the common flexor tendon at its insertion onto the medial humeral epicondyle.

On XXXX, XX, evaluated the patient for left elbow pain. The patient reported left elbow pain was sudden and occurred in a persistent pattern for XX. The patient reported XX onto the left elbow. The elbow pain was moderate to severe and rated at 7/10. The elbow pain was located over the left medial elbow. The symptoms were associated with stiffness, weakness, decreased ROM and swelling. The flexor pronator origin was point tender and resisted forearm pronation produced elbow pain. The patient also had pain with lifting and gripping. XX discussed the result of MRI. An examination of the left elbow showed tenderness at the flexor pronator origin and weakness with strength testing (resisted forearm pronation producing elbow pain). XX diagnosed left elbow pain and left Golfer's elbow/medial epicondylitis. XX discussed the treatment options. The patient opted for a cortisone injection.

Per utilization review dated XXXX, the request for cortisone injection under ultrasound guidance was denied based on the following rationale: *"Based on the clinical information submitted for this review and using the evidence-based, peer-reviewed guidelines referenced above, this request is non-certified. Per evidence-based guidelines, cortisone injection for the elbow is not recommended as a routine intervention for epicondylitis or ulnar neuropathy, based on newer quality evidence. The guidelines also noted that significant short-term benefits of CSI are paradoxically reversed after six weeks, with high recurrence rates, so this treatment should be used with caution for epicondylitis. Exceptional factors are not identified. Thus, the request is not supported."*

Per reconsideration review dated XXXX, the appeal for left elbow cortisone injection under ultrasound guidance was denied based on the following rationale: *"Based on the clinical information submitted for this review and using the evidence-based, peer-reviewed guidelines referenced above, this request is non-certified. The guidelines specifically note that injection is not recommended for medial epicondylitis. Exceptional factors were not present to necessitate the requested injection. Thus, the request for left elbow cortisone injection under ultrasound guidance is upheld and remained not medically necessary."*

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

Criteria used in analysis: Official Disability Guidelines

Corticosteroid injections,

Not recommend as a routine intervention for epidcondylitis or ulnar neuropathy, based on newer quality

evidence. There is also little specific evidence to support elbow intra-articular or bursal injections. When approval occasionally occurs for individual patients beyond these guidelines, then only a one-time injection using lower corticosteroid doses and minimal-to-no intra-articular anesthetic would be advised.

Epicondylitis (lateral, medial): Not recommended. Historically a single epicondylar corticosteroid injection (CSI) was suggested for short-term relief, but long-term outcomes could be poor. Significant short-term benefits of CSI are paradoxically reversed after six weeks, with high recurrence rates, so this treatment should be used with caution for epicondylitis. While there can be brief pain relief, patients requiring multiple CSIs have a guarded prognosis for continued nonoperative management. CSI does not provide any long-term clinically significant improvement of outcomes for epicondylitis, so rehabilitation should be first line treatment for acute cases, although a single injection combined with work modification might have some benefit.

The patient has had rehabilitation and pain for XX. The ODG does support a single injection combined with work modification. The patient should be made aware of the high recurrence rates and potential harmful risk of CSI. The request is reasonable and supported by the ODG and is certified.

Medically Necessary

Not Medically Necessary

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

**X ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**